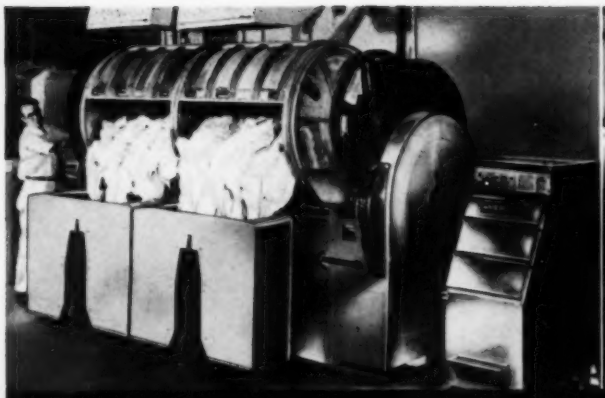
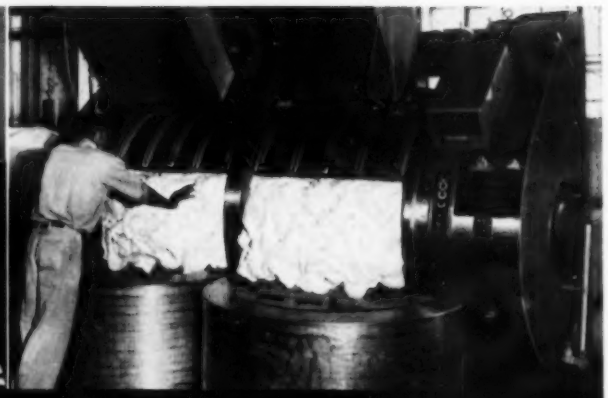
APRIL, 1961

Journal of The Canadian Hospital Association

Canadian Hospital



CASCADE® Unloading Washers, with Full-Automatic Controls, give unexcelled efficiency and tremendous labor savings in large, highly automated laundry departments.



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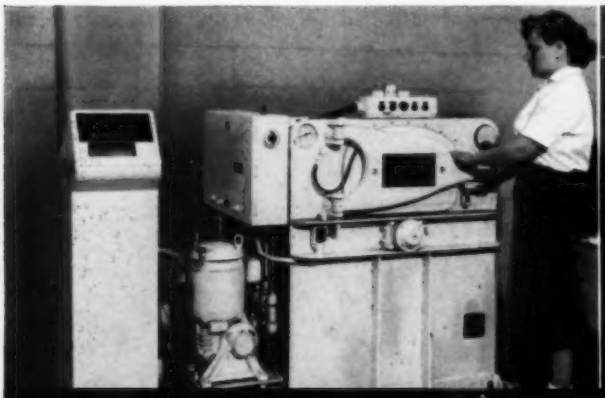

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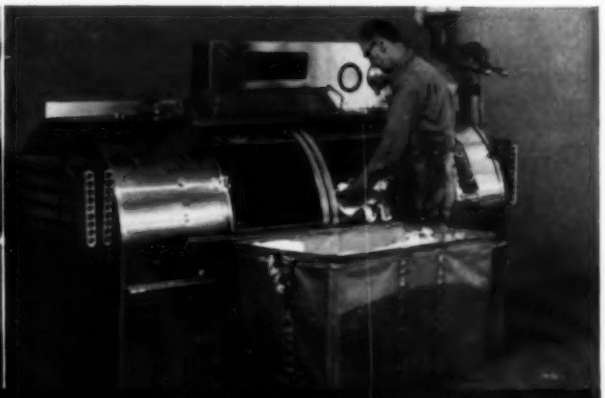

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CANADIAN HOSPITAL

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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CCAB

Contents

April, 1961, Volume 38, No. 4

Cover Picture—Guelph General Hospital School of Nursing.

See also Page 48

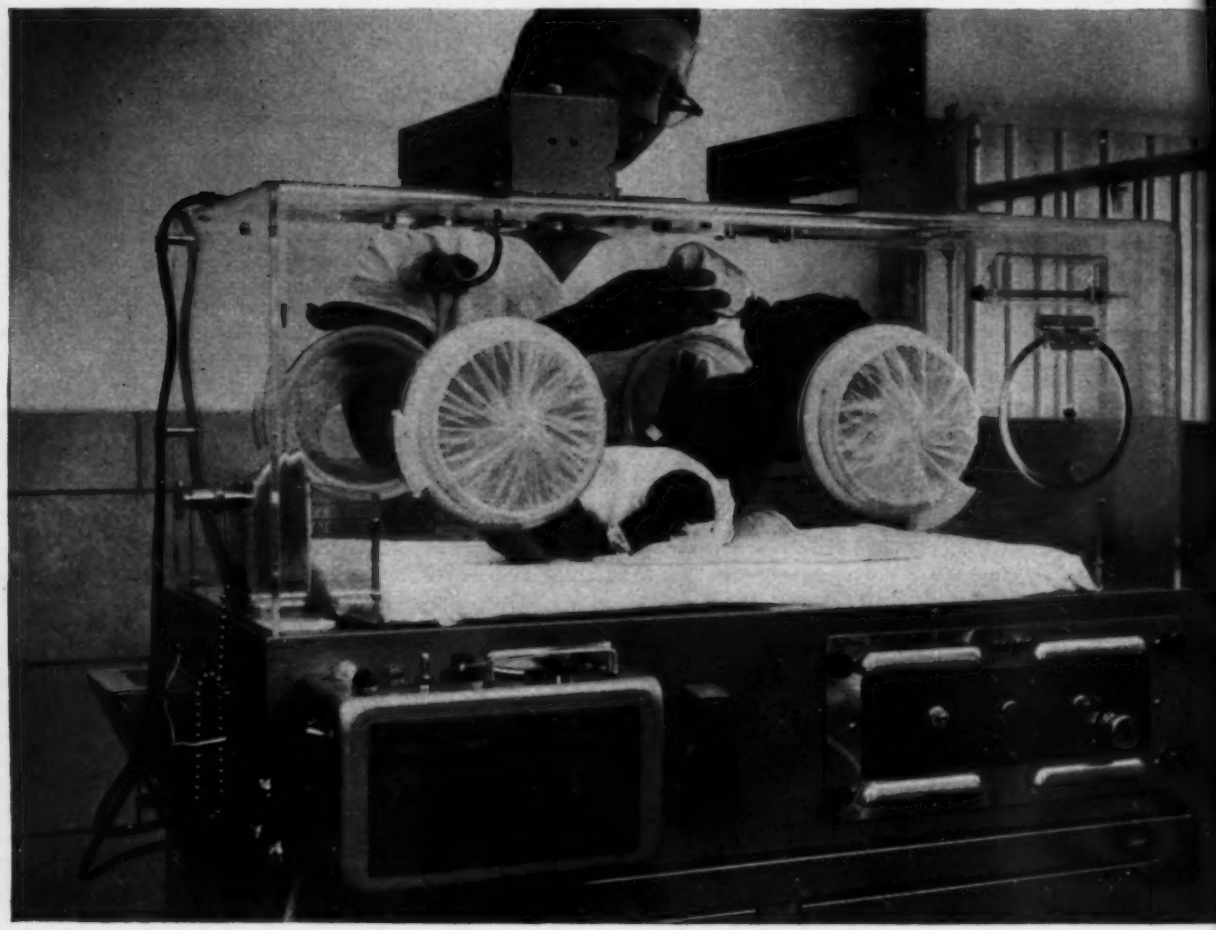
Subscription rates: $5.00 a year first subscription; each additional one $2.50 — in Canada, United States and Great Britain. The rate to other countries $5.50 a year.

Now, for the first time . . .

the premature infant can maintain his own constant body temperature indefinitely . . . the new

Infant Servo-Controller for the Isolette

provides automatic body-temperature control until the natural thermoregulatory mechanism can mature and take over



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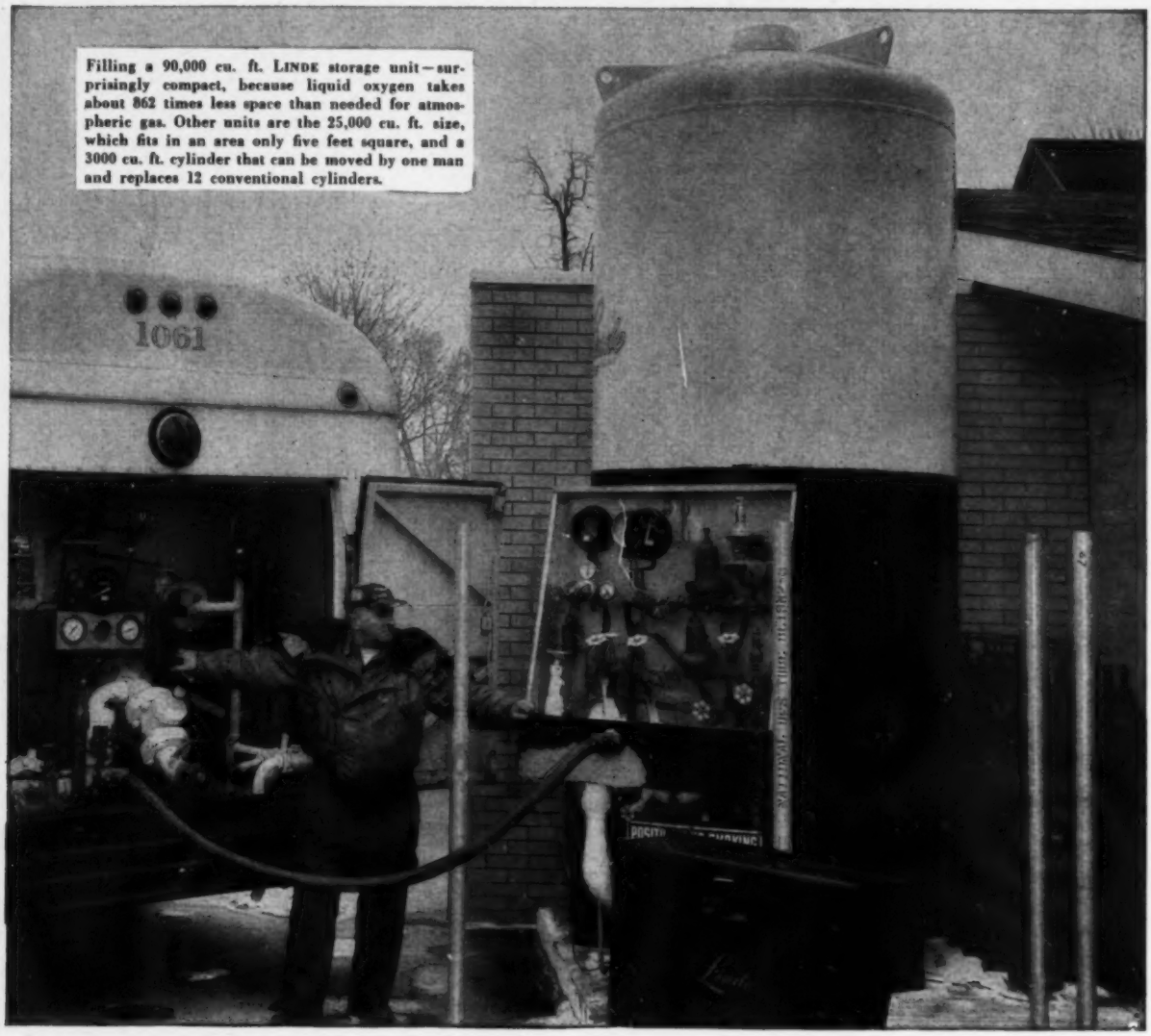

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notes about people

Georgetown Appointments

H. Graham Gilhooly has been appointed to the position of administrator at the new Georgetown and District Memorial Hospital, Georgetown, Ont., which will open in June. Before this appointment, Mr. Gilhooly was business manager at Cornwall General Hospital for the past two years and administrator of the Lady Minto Hospital at Cochrane, Ont., before that. Mr.

H. Graham Gilhooly

Gilhooly entered the hospital management field with the British Columbia division of tuberculosis control in 1954 at Tranquille Sanatorium. He is a graduate of the extension course in hospital organization and management sponsored by the Canadian Hospital Association.

Zona Hopwood was appointed director of nursing at the hospital, effective March 15. Miss Hopwood is a graduate of the St. Thomas School of Nursing and obtained her B.Sc. degree in nursing administration from the University of Western Ontario. She is at present preparing for her Masters degree in the subject. Miss Hopwood will take up full-time duties at the hospital on June 1.

Rev. Sister Margaret O'Grady

Rev. Sister Margaret O'Grady, who directed the Edmonton General Hospital as Sister Superior from 1940 to 1947 died early last month. Sister O'Grady trained as nurse in St. Boniface, Man., and took up her first duties at the Regina Grey Nuns' Hospital. She also held positions at Holy Cross Hospital in Calgary, and as Sister Superior of St. Paul's Hospital in Saskatoon, Sask.

Staff Appointments at Kingston General

Sylvia Mary Burkinshaw

Sylvia Mary Burkinshaw has been appointed director of nursing at the Kingston General Hospital. Miss Burkinshaw was born and educated in England where she had varied experience such as staff nurse in Scarborough General Hospital, Yorkshire, active service in Queen Alexandra's Royal Naval Nursing Service and as instructor at University College Hospital in London. In 1955 Miss Burkinshaw came to Canada and took, first, the position of evening supervisor in The Hospital for Sick Children in Toronto and then as supervisor of nursing assistant groups. In 1958 she became associate director of nursing. Miss Burkinshaw also obtained her Bachelor of Nursing degree from McGill University.

Miss Burkinshaw is an active member of the Registered Nurses' Association of Ontario and was a member of the Working Party set up to consider the establishment of a central nursing school in Ontario.

James B. Flett has recently joined the staff of the same hospital in the capacity of assistant administrator (finance). Mr. Flett was formerly associated with the Royal Victoria Hospital in Montreal, where he held the positions of purchasing officer, assistant controller and latterly staff assistant to the controller.

At the same time two other staff changes have been announced at Kingston General. Peter Carruthers has been promoted from assistant-to-the-superintendent to assistant administrator (professional) and William Robb has been promoted to assistant administrator (plant) from administrative assistant.

James B. Flett

Night Nurse Retires at T.G.H.

Bertha Woolford has retired from the Toronto General Hospital, Toronto, Ont., after having been on supervisory night duty continuously for 34 years. Miss Woolford joined the hospital in 1927 as night supervisor and was appointed to the private pavilion when it was opened in 1930. Four years later she was appointed assistant director of nursing (nights), the position she held until her retirement. Miss Woolford was honoured with a presentation and tea by the staff.

Administrator at Kenora General

The board of governors at the Kenora General Hospital, Kenora, Ont., has announced the appointment of A. C. Duncan as administrator of the hospital. Previous to this appointment Mr. Duncan was assistant administrator at the Misericordia Hospital in Edmonton and five years previous to that he was with the Misericordia General

(concluded on page 20)

SINCE 1885
RÜSCH

NOW IN CANADA

64 Gerrard Street East
Toronto 2, Ontario.

People

(concluded from page 14)

Hospital in Winnipeg, Man. Mr. Duncan is a graduate of the hospital organization and management course given by the Canadian Hospital Association.

New Manager at Rehabilitation Hospital

A new manager has been appointed for the Manitoba Rehabilitation Hospital in Winnipeg. He is Arthur H. Atkins who recently arrived from England. Mr. Atkins was for the past ten years chief lay administrator at the Queen Elizabeth Hospital in London and prior to that he was administrative assistant at Banstead Hospital in Surrey. He also holds diplomas from the Institute of Hospital Administrators (Eng.)

New Administrator at Saguenay

Guy St-Onge is the newly appointed administrator of the Saguenay General Hospital, Arvida, Que. Mr. St-Onge is a graduate of the University of Montreal, where he received his B.A. and B.Com. degrees, before obtaining his Master's degree in hospital administration. Before coming to Arvida, Mr. St-Onge was assistant to the director of hospital administrative services at Hôpital Ste-Justine in Montreal.

P.R. Head at St. Joseph's

Head of the newly-established public relations department at St. Joseph's Hospital in Victoria, B.C., is Maurice Cownden. Mr. Cownden joins the hospital after 11 years in radio broadcasting in various B.C. centres. His activities will include organizing the forthcoming building fund drive and establishing a staff magazine.

- A. A. Dougan, M.D., has been appointed medical director of the Sherbrooke Hospital, Sherbrooke, Que. The appointment was announced by the administrator of the hospital.

- Glenholme Hughes has been elected new chairman of the board of directors of the Memorial Hospital in Bowmanville, Ont. Rex Walters was elected vice-chairman.

- Constance Jane Winter has been appointed director of nursing at the Westminster Hospital in London, Ont. She arrived for her new position from Ottawa where she was assistant to the director of nursing services in the Department of Veterans Affairs.

- The newly elected president of the medical board at the Hôtel-Dieu de St-Joseph, Edmunston, N.B., is Dr. J.-B. Gaudreau, who is taking the pace of Dr. Claude Gaudreau.

- The administration of Hôpital St-Joseph du Précieux Sang, Rivière-du-Loup, Que., has found it necessary to have a medical director on the staff. This position has been filled by Ladislas Dufour, M.D., a specialist in anaesthesia, who has been with the hospital since January, 1960.

Seat Belts For Small Patients

In United States, hospitals in six states are reported using airplane seat belts as safety devices for keeping small children from falling out of bed, orthopaedic carts or wheel chairs. United Air Lines in Salt Lake City, Utah, originated the idea of donating the belts to children's hospitals.

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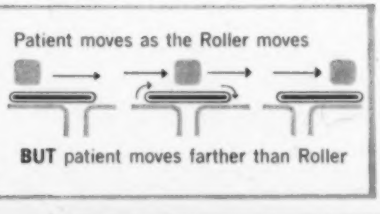

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A.C.H.A. Activities

Amendments to By-Laws

Recommendations for "moderately conservative" changes in the by-laws of the College have been made by a special By-laws Committee and by the professional society's governing body, the Board of Regents.

The suggested changes relate to admission and advancement and have three major objectives, according to Peter B. Terenzio, chairman of the By-laws Committee. These are: (a) to give a broader base for membership eligibility; (b) to enable course graduates to become members sooner; and (c) to upgrade fellowship by emphasizing personal qualifications rather than "automatic" advancement.

To facilitate the study of these proposed changes, a special leaflet containing the recommendations juxtaposted to the existing by-laws has been sent to the entire membership for review.

Action on these suggestions will take place at the General Membership Assembly of the College, scheduled for Monday, September 25, at Convention Hall in Atlantic City, N.J., site of this year's meeting.

Seek Book Award Suggestions

The members of the College have been approached by the Book Award Committee for the Fifth Annual Congress on Administration asking for recommendations for the 1961 James A. Hamilton-Hospital Administrators' Book Award.

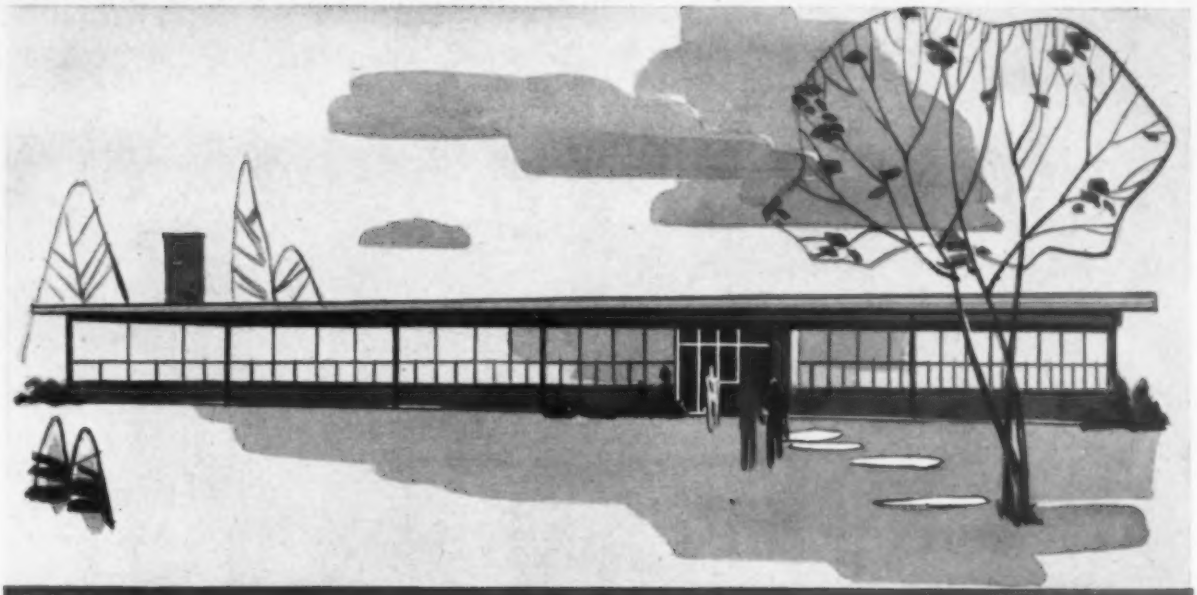
A postcard has been sent to all fellows, members and nominees of the society asking for their suggestions as to books they believe worthy of the committee's consideration.

In order to qualify for the 1962 award—renamed this year as a tribute to Mr. Hamilton by alumni of the program in hospital administration at the University of Minnesota which he heads as director—the book must (a) have meaning to the whole field of administration; (b) have made a valuable contribution to the literature on administration; (c) give promise of making a significant impact on the advancement of administration as a science; and (d) have been published in 1960.

In addition to soliciting the recommendations of the membership, the Book Award Committee is also asking for suggestions from deans of graduate schools of business at prominent universities, book publishers, editors of professional magazines publishing reviews of management books and directors of graduate programs in hospital administration, to name a few of the major sources.

The committee, headed by Robert S. Hudgens, director, School of Hospital Administration, Medical College of Virginia, Richmond, will meet late this spring to begin appraisal of the recommendations that have been made by these various sources.

Previous winners of the College's book award have been Herbert J. Simon *(Administrative Behavior)*; Chris Argyris *(Personality and Organization)*; Harold J. Leavitt *(Managerial Psychology)*; and Melville Dalton *(Men Who Manage)*. ■



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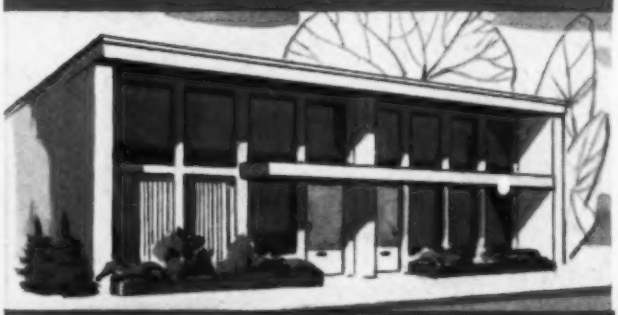

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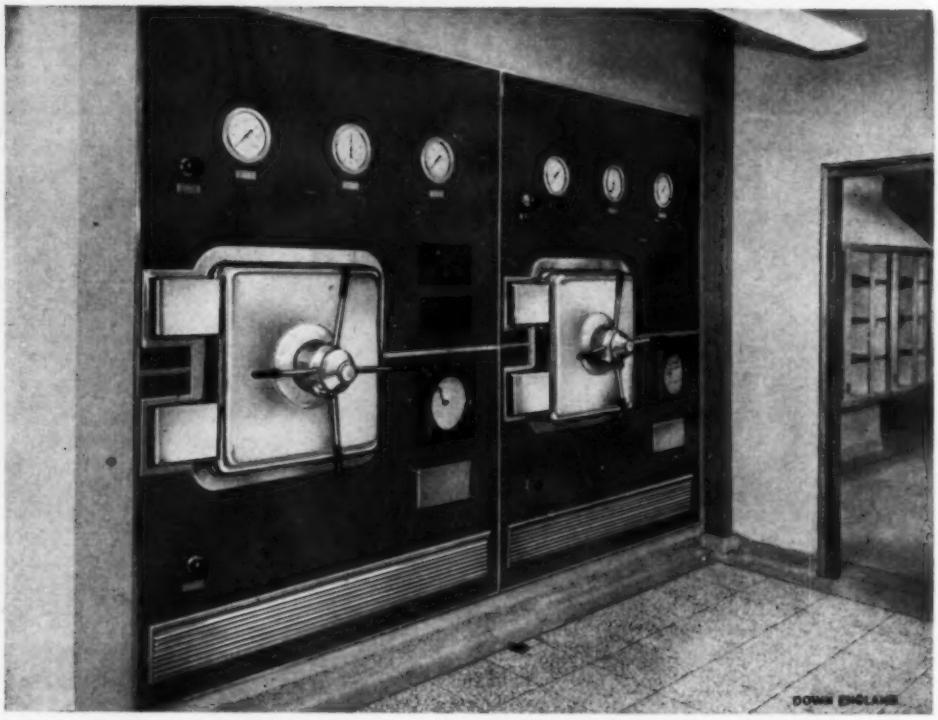

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- "Penetration time" is no longer a factor.
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In addition to much wanted safety, you have the much proven pre-pack efficiency that yields steady dividends in terms of time gained, labor spared and money saved.

For the latest—as well as the safest—in hospital dressings, see Curity.

1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

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all one motion: pull tab . . . dressing's ready . . . one hand's free

Coming Events

1961

April 17-19—Institute on Dietetics, sponsored by the O.H.A., and the Ontario Dietetic Association, Park Plaza Hotel, Toronto.

April 19-21—Quebec Hospital Association, Queen Elizabeth Hotel, Montreal, Que.

April 27-29—Canadian Physiotherapy Association Congress, Queen Elizabeth Hotel, Montreal, P.Q.

May 1-5—Second Canadian Advanced Institute, A.C.H.A. and O.H.A., Royal York Hotel, Toronto, Ont.

May 23—Meeting of Association Secretaries, 25 Imperial Street, Toronto 7, Ont.

May 24-26—Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ont.

May 26-27—Catholic Hospital Association of Canada Biennial Convention, Montreal, P.Q.

June 2-5—Canadian Public Health Association, University of Saskatchewan, Saskatoon, Sask.

June 5-6—O.H.A. Institute on Public Relations, O.H.A. headquarters, Toronto, Ont.

June 5-9—Maritime Hospital Association, Nova Scotian Hotel, Halifax, N.S.

June 5-9—12th International Hospital Congress, Island of S. Giorgio Maggiore, Venice, Italy.

June 5-29—Hospital Organization and Management Summer Session, Winnipeg, Man.

June 12-15—Catholic Hospital Association of United States and Canada, Detroit, Mich.

June 12-16—25th C.S.L.T. Convention, Royal Alexandra Hotel, Winnipeg, Man.

June 13-15—26th annual convention of the Canadian Dietetics Association, Hotel Vancouver, Vancouver, B.C.

June 19-23—Canadian Medical Association, 94th Annual Meeting, Queen Elizabeth Hotel, Montreal, P.Q.

June 20-21—Catholic Hospital Conference of Saskatchewan Annual Convention, Saskatoon, Sask.

June 20-23—Western Canada Institute, Saskatoon, Sask.

June 23-29—Third International Convention of X-ray Technicians, C.S.R.T. and A.S.X.T., Queen Elizabeth Hotel, Montreal, P.Q.

June 25-July 21—Fourth Annual Hospital Administrators' Development Program, sponsored by The Sloan Institute of Hospital Administrators, Cornell University, Ithaca, N.Y.

June 26-28—Comité des Hôpitaux du Québec Convention, Montreal Show Mart Inc., Montreal, P.Q.

Sept. 10-14—International Tuberculosis Conference, Royal York Hotel, Toronto, Ont.

Sept. 24—Convocation Ceremony, A.C.H.A., Convention Hall, Atlantic City, N.J.

Sept. 25-28—American Hospital Association, Atlantic City, N.J.

Oct. 3-5—Manitoba Hospital and Nursing Conference, Royal Alexandra Hotel, Winnipeg, Man.

Oct. 5-6—Saskatchewan Hospital Association Annual Meeting, Saskatchewan Hotel, Regina, Sask.

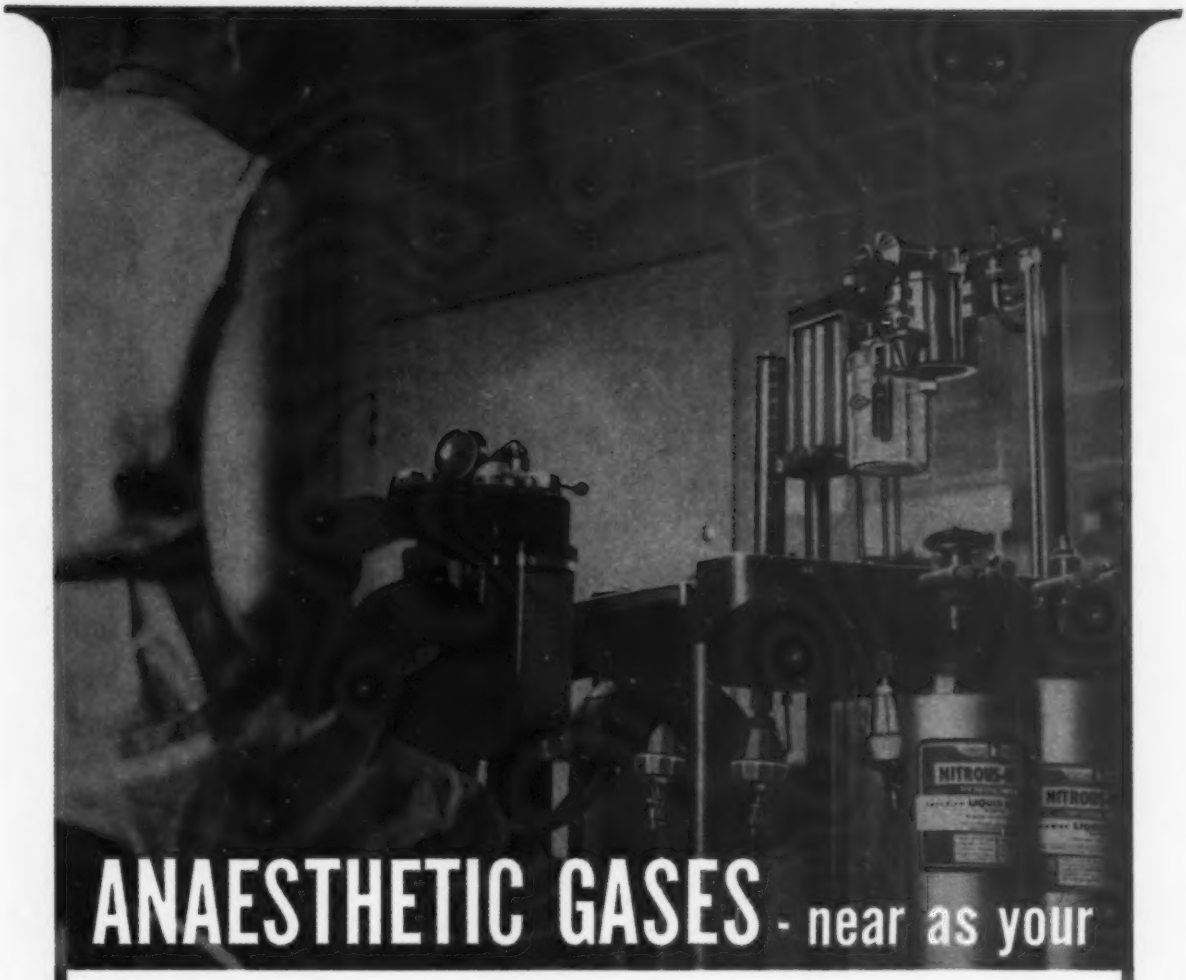
Oct. 8-9—Catholic Hospital Conference of Alberta, Calgary, Alta.

Oct. 10-12—Associated Hospitals of Alberta Convention, Calgary, Alta.

Oct. 15-16—Catholic Hospital Conference of British Columbia Annual Convention, St. Vincent's Hospital, Vancouver.

Oct. 17-19—British Columbia Hospitals' Association Convention, Hotel Vancouver, Vancouver, B.C.

Oct. 23-25—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.



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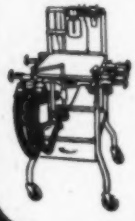

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EDITORIAL

Nursing Education Re-examined

WE ARE pleased, in this issue, to devote most of our space to articles which throw light on problems facing the nursing profession and administration with respect to hospital staffing. Continuous efforts are being made to provide more nurses trained, not only for bed-side care, but prepared and willing to offer leadership as well. In the past, training for supervision and administration has been, for the most part, at the university level. But those people devote many years, and highly expensive ones, to study; and there are not enough of them. In Canada this group can probably all be absorbed, eventually, as directors of nursing service in hospitals or as instructors in schools. So who is to become the head nurse, the leader under the team concept?

In February an institute was held under the joint auspices of the Registered Nurses' Association of Ontario, the Ontario Hospital Association and the Ontario Hospital Services Commission. This was a study period for directors of nursing schools in that province. Five articles based on addresses presented there are published as a symposium in the following pages and these tell of educational trends and experiments taking place in Ontario.

Another institute, held in Sudbury last month, under the sponsorship of the Ontario Catholic Hospital Conference, stressed the importance of staff orientation programs and of in-service training for all categories of people who serve the patient. In the discussion groups, increased empathy toward the patient, on the part of all nursing personnel, was urged. And this month another institute, held in Toronto, was sponsored by the Registered Nurses' Association of Ontario, the Ontario Hospital Association, and the Ontario Medical Association. Its aim was "to assist the head nurse to develop skills in assessing the patient's needs and in fulfilling her unit responsibility."

An interesting venture is the joint sponsorship by the Canadian Nurses' Association and the Canadian Hospital Association of an in-service training program for head nurses. This course is now being developed and will be offered to selected head nurses and other senior nursing personnel, commencing in the fall of this year. The course is administered by a joint committee of the two sponsoring associations with Kathleen Ruane as director. This project has been made possible through the generous assistance given by the W. K. Kellogg Foundation.

All this activity is but typical of the efforts being made across the country to adapt the nursing resources available to meet, as well as humanly possible, the health needs of a rapidly growing population.

This is Library Week in Canada

BETWEEN April 16 and 22, libraries across Canada are celebrating "Library Week" for the third consecutive year. The purpose of the Canadian Library Week Council, Inc., is to call attention to library services and the value of books. Its patron is the Prime Minister, the Rt. Hon. John G. Diefenbaker. Slogan for the week is "Reading is the key—to a healthy democracy."

Perhaps in this connection the key word for readers of this journal is "healthy". Have books a therapeutic value to the person who is ill? Surely the answer is "yes", especially for those who are habitual readers. For them to be deprived of a choice of books can be a real hardship and lead to general discomfort and discontent. Whereas, to quote Emily Dickinson, "There is no frigate like a book to take us lands away." (See "Why a Library?" by Sr. Mary James in *Canadian Hospital*, March, 1960.) If the patient reads only for diversion, that in itself can lessen the uneasiness caused by nagging pain. Avid readers who find themselves tied down for a period of rehabilitation will appreciate to the full any good library service which the hospital can provide.

Then an eager librarian, or voluntary worker, may well encourage the person who is quite unread to dip into illustrated books, and there is a good chance that real interest may be aroused. If illness could lead to a life enriched, a librarian would have reason to feel great satisfaction. And this does happen many times, especially among patients with extended illness.

We are not suggesting here that a library service for patients should be supplied as part of the operating cost of the hospital. This is one sphere where the people of the community can be of concrete assistance. A library service may be undertaken by the women's auxiliary or a service club. The manner in which this service has long been carried out at the Ottawa Civic Hospital is described by Douglas R. Peart on page 50 of this issue.—*J.F.*

Edith R. Dick,
Toronto, Ont.

nursing education in ontario

Trends and d

A symposium of five articles presented at an institute for directors of schools of nursing, sponsored by the R.N.A.O., O.H.A. and the O.H.S.C.

TO PROVIDE courses for the young people in this province who want to qualify as registered nurses is a formidable project. The census of 7,221 students now in schools of nursing represents an increase of 18 per cent in the past five years. It does not, however, represent an increase in the percentage of the population in the 17 to 19 years age group which elects nursing as a vocation. This has remained substantially the same in the past five years at 5.8 per cent. Even at this fixed rate, a school of nursing census of 10,508 can be anticipated by 1968. It is thought by some that this may be too conservative an estimate. These people suggest that when the teaching profession has a surplus of teachers as forecasted for 1963, the number of 17 to 19 year olds, who choose nursing, may exceed the present rate of 5.8 per cent. This may be cogent reasoning when one considers that the teacher's college is the school of nursing's chief competitor.

The increase in student census from 6,079 to 7,231 in the past five years has been absorbed by the existing 59 schools plus two new ones.

A tabulation completed four months ago, based on reports from 55 hospital schools for the year 1959, indicated, on the basis of the available clinical field, that of the 19 schools *with adequate* teaching and residence accomodation, 8 were enrolling to capacity of their clinical facilities; 8 were under capacity to the extent of 225 students; and 3 were enrolling beyond their capacity. Of the 35 schools *without adequate* teaching and/or residence accomodation, 5 were enrolling to capacity of their clinical facilities; 24 were enrolling less than their capacity—by 900 students; and 6 were enrolling beyond their capacity.

It would seem fair to say that in the case of the 24 schools without adequate school facilities, which were not using the potential of the clinical field, the chief deterrents were lack of physical facilities and probably lack of teaching staff.

The author is director of the Nursing Branch, Department of Health, Province of Ontario.

developments in hospital schools

In the same five-year period the number of nurse instructors in all schools increased from 386 to 540 or by 39.8 per cent. The teacher-student ratio in 1956 was 1:15. At present it is 1:13; this figure does not include 50 part-time nurse instructors nor 50 additional full-time nurses, who have the combined responsibility for the administration of the school and teaching.

It is apparent that the ambitious instructor is seeking more preparation. While government bursaries assist a limited number of persons to obtain first level preparation for teaching, there is little assistance for the experienced instructor to prepare herself for increased responsibility and leadership.

The frequent turnover of teaching personnel continues to be a conditioning factor in the conduct of programs. Some observers think that the status of the instructor needs more recognition and that the compensation for her services should be on a graded scale according to qualification.

Before speaking of the common characteristics of the hospital school of nursing, it may be useful to review the legislative framework within which it operates.

Legislation permits the board of governors of a university or hospital to conduct a school of nursing to prepare a registered nurse. Under two acts it sets controls through minimum standards which cover such items as admission requirements, syllabus, staffing, facilities and the advisory school committee.

These statutory requirements do not impose uniformity in either the organization of the school or its operation. Consequently, there is considerable local variation in policies. At present, the 62 schools of nursing offer 3 types of programs. Two schools offer 4-year basic degree programs; one offers 2-year diploma programs; and there are 59 which offer 3-year diploma programs. Of the 59 diploma courses of three years: one is conducted by a university; three are conducted by the Ontario Department of Health in mental hospitals; and 55 are conducted by public hospitals. These account for 93 per cent (6,749) of the total student census.

The distribution of schools has been determined by the availability of teaching facilities and the interest of boards of trustees on behalf of the citizens. The main source of supply of registered nurses is the large general hospital school. Today, 3,500, roughly one half of all the students are enrolled in 15 schools.

It can be said that through the years local communities have supported nursing education through the efforts of citizens on boards of trustees, through public subscriptions and through payment for hospital care. The developments in schools of nursing have been local enterprises and consequently the various schools have different characteristics.

When a board of trustes is granted approval under the Nursing Act to conduct a school, only minimum requirements exist as guide lines. There is no blue print. An encouraging trend is the increasing tendency of board of trustees to provide for the school of nursing in by-laws. Usually, they include a statement of purpose, lines of responsibility, and standing school committees.

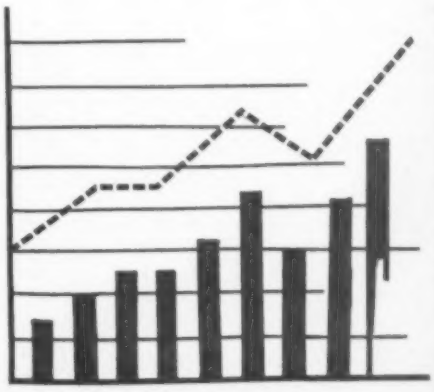
The school is directed by a registered nurse who is appointed by the board. In all but eight schools the director is responsible for the nursing department of the hospital also. The director usually has had one year of study at university. The directors of 27 hospital schools have university degrees.

The director of the school is responsible to the board through the administrator. She is required to be present at meetings of the board when matters concerning the school are under discussion and to submit an annual report on the school to them. This is the accepted practice increasingly.

The board appoints an advisory school of nursing committee. This has been a consistent trend for many years. Where it functions well, it has proved to be a means to enlist the interest of the community and to develop a sense of responsibility for the school locally.

The faculty of the school is selected by the director. It is being demonstrated every day that progress is made more readily when the faculty plans all aspects of the program jointly. There is a noticeable effort on the part of the faculty to adopt a mutual philosophy of education, to define goals and to scrutinize the content of the cur-

(concluded on page 64)



Operating costs in hospital schools

Part I

R. W. I. Urquhart, M.D.
Toronto, Ont.

THE AUTHORITY through and by which the Commission has become involved in the problem of nursing education is contained in the Act under which the Commission was created, Section 7 (d): I quote "It is the function of the Commission and it has power—to establish and operate, alone or in co-operation with one or more organizations, institutes and centres for the training of hospital and related personnel."

To me this is a definite directive to become involved in the training of nurses, and other hospital personnel, which we cannot ignore—and the directive becomes all the more binding because of Section 12 of the same Act which states, and I quote, "In the event of conflict between any provision of this Act and any provision of any other Act, the provision of this Act prevails".

There is, in addition, the traditional and very necessary relationship of hospitals to training programs — particularly the training of student nurses where it is essential that the hospital provide the clinical facilities for such training. It must also provide the clinical facilities for the training of medical personnel, technicians, and certified nursing assistants, et cetera. No one can deny that hospitals are the Commission's business. Whether we like it or not, the Commission is very much involved in the education of hospital and related personnel, and it is the Commission which must find the money to underwrite the cost of these programs.

We must admit that there is logic in the position taken by those who drafted the Act. If the Commission has the responsibility of seeing to it that funds are available for these training programs, it cannot avoid the responsibility for seeing that the funds are expended so as to provide the best value for the money.

In doing so it would seem to me that it is quite right and proper that it should work with and perhaps through the various agencies which traditionally have been involved in these programs. Thus, if my understanding of the present situation is correct, we must recognize that the hospitals, the Registered Nurses' Association of Ontario and the Department of Health must be involved very intimately in the implementation of the Act. It may be that there should be some further clarification of responsibility between ourselves and the Department of Health, but that is an internal governmental matter.

To these must be added of course the associations, *i.e.*, the R.N.A.O. in its association as distinct from its legal entity, the Ontario Hospital Association and the Ontario Medical Association. There may also be other groups to which reference should be made. Surely, with all this talent, the problems inherent in nurse education can be solved. Indeed it should be possible to resolve problems which, from my personal point of view as a physician, have been in existence ever since I began to practise in Toronto some 36 years ago.

The author

The author is chairman, Ontario Hospital Services Commission.

Present Situation

The Commission and its staff have given a good deal of thought to the assessment of its responsibilities in the field of nursing education. It has drawn heavily upon the experience of those who have been involved in this field, as well as upon the very many worthwhile studies and experiments which have been made throughout the years. It is hoped that today's very real problems can be solved in a practical, realistic fashion which will stand the test of time, rather than on the basis of expedient short-term solutions for difficult but perhaps transient local situations.

We must bear in mind the urgent need to maintain a sufficient supply of nurses to meet the requirements of an expanding hospital system, and the equally urgent need to make sure that our educational programs shall be so oriented as to maintain the quality of nursing care which is felt to be so essential —in a world where it seems at times increasingly difficult to retain the high standards.

Let me then set out the basic principles which are as follows:

(a) nurses should be trained as quickly as possible consistent with sound educational principles;

(b) nurses should be trained as thoroughly as possible in order to assure quality of patient care;

(c) nurses should be trained as economically as possible in the interests of both the student and the community;

(d) training should be regarded as an educational experience and not as a means of augmenting the nursing service of the hospital to the detriment of the educational program; and

(e) the cost of nursing education should be related solely to the expense involved in the education of the student nurse.

It may be that there are other basic principles but these illustrate our point of view. The acceptance of these principles involves us immediately in other considerations and there are implications which, no doubt, are already apparent. For example, it is clear that the Commission recognizes an urgent need for additional nurses. To train nurses quickly and adequately, efficiency in educational procedures must be obtained and the additional costs may well be considerable. Again, if the training of nurses is to be an educational experience unrelated to service to the hospital—apart from such service as is involved in clinical training and practice, it is obvious that it becomes necessary to reassess costs in relation to (a) education, and (b) service—where service has been a traditional factor in the hospital's economy.

The Commission therefore must be prepared to support the costs of education in the nursing schools on the basis of need; and, since the need is entirely related to the costs of education, it should vary little from school to school. It is our considered opinion that it becomes unnecessary for the Commission to subsidize schools so as to encourage competition between schools for students. This would increase costs without affecting the content of educational experience. In other words, there should be no discrepancy between educational subsidies offered to students in various schools.

It follows, of course, that where the service element has been removed from the educational program, this service must be obtained from other sources and the cost must be met by the Commission through the mechanism of the hospital budget.

It seems that there is some validity in the suggestion that the costs of the various types of education provided through the mechanism of the hospital, *i.e.*, nurse, intern, and technician, should be examined and separated out from the costs of patient care. This is not to say that these costs should not be met in the budget; but it might be better to meet them on an annual grant basis entirely divorced from the per diem rate. I think it would be better accounting practice.

Factors to be Resolved

There is the traditional three-year course, the newer two-plus-one-year course and now the two-year course. All of these programs have developed over the years with almost as many variations in pattern as there are schools of nursing.

Surely we can agree that nurse education is no different from any other type of professional education—except that by tradition it seems to have retained longer than any other profession the slave-apprentice feature of the old craft guilds of England.

Surely we can agree that it should no longer be necessary to pay students to enter the profession. Personally I would much rather see the available funds go to improve the standard of training in our hospitals and schools or be used in the form of bursaries to help those who need help to enter the profession. If the problem of the eager but needy student is solved, then other factors must evolve which will make a particular school attractive to the prospective student. The main factor in the long run is the quality of the program and the reputation of the school. I do not believe that the young people of this country have yet reached the point where a few dollars one way or another will be allowed to tilt the balance.

This whole matter is fraught with problems. Perhaps if we keep basic principles in mind, the solutions will begin to emerge. ■

Components of costs

Part II

Gladys Sharpe,
Toronto, Ont.

WITHIN a framework prescribed by the Ontario Hospital Services Commission are terms of reference for its consultants on nursing. These in brief include: (1) to provide service liaison between the Commission, the Nursing Branch of the Department of Health and the Registered Nurses' Association of Ontario; (2) advising the Commission on nursing; (3) planning for and participating in institutes and conferences; and (4) research activities in hospital nursing services.

Other responsibilities include the review of construction plans as they relate to the provision of nursing service and nursing education.

As viewed by the consultants on nursing there are two basic areas of *financial* concern—the maintenance of a sufficient supply of nurses giving the quality of care required by the changing needs of society; and the education of nurses to perform the functions required of them. On the one hand is the public—expecting nurses to give competent care in hospitals, homes, schools, industries and other community agencies—on the other, the student, who expects and has the right to receive the type of education which will make her an acceptable practitioner, not only in her own community but in all the provinces of Canada.

On the basis of past experience in the conduct of schools under university and under hospital auspices, the writer shares the view expressed by a well-known nurse educator in Boston, "If each aspect of the hospital diploma program is analyzed, inequities occur not because the hospital operates the school but because the school itself fails to provide a sound educational program, which could also be true if the school was conducted by another jurisdiction."

Any institution claiming to prepare professional workers must

The author is consultant on nursing services at the Ontario Hospital Services Commission.

Form 1

Stipends 1959

Number of schools paying stipends—1st 6 months—13
2nd 6 months—39
2nd year —39
3rd year —48
Number of schools paying no stipend — 8

Variation in net amounts paid per student per month—
1st 6 months—low $5—$50 high
2nd 6 months— $5—$60
2nd year — $6—$65
3rd year — $6—$75
6 ("2 + 1") $110—$133

Total net amount paid to 4,727 students—$1,112,534
" " " " " 1,490 " — 674,600
" " " " " 1,460 " — 0

Uniforms

Total Cost—	No. of Schools	No. of Students
Borne by student	25	3,145
Borne by hospital	21	2,153
Shared by student and hospital	6	889
	52	6,187

Variations in cost of uniform per student per year ranged from $30-$128

Text Books

Of 54 schools reporting—27 placed books in the library
27 provided students with a set of text books approximate cost $45 per set

Reference books (library) expenditures ranged from $50—$2,015 per school

Graduation

Expenses as projected for 1961
Of 45 schools reporting—
5 showed a cost of less than $15 per student
11 showed a cost of between $15-$25 per student
20 showed a cost of between $26-$40 per student
9 showed a cost of $40 per student
Low—$4.76 High—$90

Form 2

Estimate of Income and Expenses of Nursing Education in 56 Hospital Schools in Ontario

Expenditures:	1959	1960	1961
Salaries	$1,944,074	$2,635,579	$3,375,796
Training Assistance	674,096	978,693	1,469,170
Perquisites	2,302,552	2,966,025	3,581,931
Admin. Supplies & Expense	415,703	490,405	551,076
Other Supplies & Expense	359,398	413,541	470,047
Depreciation	89,209	117,231	155,640
Total Expenditures	5,785,032	7,601,474	9,603,660
Per Student	857.17	1,126.31	1,422.97
Income:			
Tuition Fees	$ 68,010	$ 84,552	$ 83,383
Uniforms	8,769	22,743	32,268
Textbooks	21,447	29,996	31,975
Student Services	.....	.....	.....
Other	20,829	24,150	27,458
Total Income	119,055	161,441	175,084
Per Student	17.64	23.92	25.94
Net Expense	5,665,977	7,440,033	9,428,576
Per Student	839.53	1,102.39	1,397.03

Prepared by Hospital Finance Division, O.H.S.C., February 7, 1961.

provide the organization, the resources and the facilities necessary to establish its work on an educational basis.

In the past the reason given for the existence of mediocre schools was lack of financial assistance. For years nursing leaders have urged that public funds should be made available for nursing education. Prior to 1959, each patient who received care in a hospital which conducted a school of nursing contributed to the cost of *that* school, whereas hospitals without schools, and the patients cared for in them, made no contribution to basic nursing education.

Since the inauguration of the hospital insurance plan, however, nursing education in Ontario has been supported by federal and provincial exchequers and the 95 per cent of its citizens who are policy holders. Therefore, today *public* funds are financing nursing education.

One has only to read current literature to realize that educational institutions at *every* level are facing spiraling costs that show no signs of stabilizing. Universities and colleges are tending to pay increasing attention to determining the pattern of costs they face. Education for nursing is no exception to this trend and in this field certain factors make financial problems more pronounced. For example, in a number of localities of the province there is a shortage of nursing personnel but, even more serious, is the general shortage of nurses qualified to administer, supervise and teach nursing.

A second factor is that, while a hospital is as essential in the education of a nurse as it is in the education of a doctor, the medical school (to which the doctor pays tuition and other fees) controls the clinical education of the doctor; whereas similar controls are less likely to be recognized by a hospital with respect to its school of nursing, when tuition or other fees, where required, are not based on cost.

Finally, there are the changes in health care which are characteristic of our day. Nursing, in common with other health professions, has had to meet new demands which require a nurse with greater knowledge and diversity of skills than heretofore. All these factors point up the necessity for a searching scrutiny of nursing education and its financing.

(concluded on page 66)

patterns leading to the Nightingale School

Mrs. Blanche Duncanson
Toronto, Ont.

NURSES as citizens and members of society have continually strived through their professional organizations to improve their service rôle to meet the changing needs of society. Many efforts have been made to improve the quality of nursing service through the preparation of the nurse. These efforts are revealed in changed and changing patterns of nursing education.

To comprehend fully these changing patterns, they must be viewed against the background of historical and social influences of which only a few will be highlighted here. Too often, the influence of Florence Nightingale upon nursing is interpreted as being the exaggerated selflessness and devotion of the nurse. Important as these qualities are, the real influence exercised by Florence Nightingale has been through the establishment of the first organized school of nursing. One hundred years later the same principles which were enunciated by her in the development of the Nightingale School of Nursing, at St. Thomas' Hospital in London, England, are still considered ideal and are being sought in the present day development of schools. The curriculum was designed to meet the students' needs and the school was an entity, administered separately from the hospital, although it used the hospital facilities. It was financed through the Florence Nightingale Foundation, which had been set up in recognition of Miss Nightingale's work in Crimea.

At this same period in history, medical knowledge expanded greatly and opened wide possibilities in medical and surgical practice; these in turn caused rapid change in hospital conditions and finally the hospital service itself brought an increased demand for nursing. Thus it was logical enough that the school for the teaching of nursing should become identified with the hospital in the provision of service for the patients. These new schools were placed directly under the authority and administration of the hospital trustees or governors and soon even the Nightingale School lost its original independence as an educational entity.

In the relatively simple hospital conditions of that time, the apprenticeship type of training was adequate, but the arrangement has lasted, with some revision, up to the present. A similar method served in the preparation of most professions in their early stages, but has been abandoned long since.

A break with the customary form is the independent school of nursing. It is not new; it is a return to tradition—to the original pattern of a school as organized by Florence Nightingale.

It is unfortunate that the word "independent" has been found necessary to describe the educational function of a school of nursing. The word "school", by itself, should be adequate to connote this function. Independence for a school should not be interpreted as the severing of all contact or relationship with the hospital or institution which provides nursing service, but rather that the school should be governed by administrative authority and should have an assured source of income so that the educational function is preserved and promoted.

It is the wish of the Association that, in the schools now owned and operated by the hospitals, a pattern of administration could be evolved which would assure the existence of the school as an entity and its educational prerogative. It is also recognized that the quality of this function should be safeguarded by comprehensive legislative controls.

A few such independent schools have been developed in some of the universities in Canada. In these the student is freed from service, over and above her practice and learning requirements.

The author

The development in Canada in 1948-1952 of an independent school not associated with a university, which could reduce the usual three year nursing course to two, was sponsored by the Canadian Nurses' Association, and financed by the Canadian Red Cross Society. The school at Windsor was called the "demonstration school." The objectives of this school were: (a) to establish nursing schools as educational institutions, separate entities in their own right; and (b) to demonstrate, if possible, that a skilled clinical nurse can be prepared in a period shorter than three years, once the school is given control of the use of the student's time—the hope being that a period of two years, or slightly more, would suffice. These two objectives are equally significant. At times, however, the emphasis has all been directed to the second one.

The author is director, Nightingale School of Nursing, Toronto, Ont.

As public financial support was not forthcoming to ensure the fulfillment of the first objective, the school ceased its operation on September 15, 1952, having functioned since January 19, 1948.

In July, 1951, the Canadian Nurses' Association asked the Canadian Education Association to undertake a joint evaluation of the Metropolitan School of Nursing. A joint committee was set up with Dr. A. J. Phillips, statistician, National Cancer Institute of Canada, as chairman, and Dr. A. R. Lord of Vancouver, an eminent educationalist, was appointed director of evaluation.

The following is a quote from Dr. Lord's Report of the Evaluation of the Metropolitan School of Nursing: "The conclusion is inescapable. When the school has complete control of the students, nurses can be trained at least as satisfactorily in two years as in three, and under better conditions, but the training must be paid for in money instead of in services. Few students can absorb substantial fees, nor can the hospital pass on such additional costs to the paying patient. Some new source of revenue is the only solution."

The influence of this demonstration can not be measured. It has been studied not only by nurses across Canada and abroad, but by members in allied fields as well.

The Canadian Nurses' Association, which is a federation of the provincial nurses' associations, believes one of its functions is to give leadership, to point toward desirable goals, and to indicate whereby these goals may be reached. For this reason, it has formulated a statement of policies regarding nursing service and nursing education. From these I should like to quote two statements regarding education: (1) The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete experience of the students. (2) Nursing requires, and has the right to expect, public and private financial support of its education.

Other policies relate to qualifications of staff and the development of the curriculum. These policies have been mentioned since they are supported by the provincial nurses' associations, and are reflected in any beliefs at that level.

In Ontario, the approval of a school of nursing is the responsibility of the Nursing Branch, Department of Health. The Registered Nurses' Association of Ontario has the legal responsibility for establishing admission requirements and the curriculum for schools, as well as the registration and discipline of registered nurses.

In 1956, the Registered Nurses' Association of Ontario was asked by the Department of Health, Nursing Branch, on the advice of the Council of Nursing, to study and suggest a suitable pattern for basic nursing education programs. The Association was happy to fulfill this request, and appointed a Working Party to undertake the assignment. In addition, it was asked to consider centralized basic courses in nursing education on a regional basis. This work was undertaken in 1956 and 1957, and the association at its 1957 annual

(continued on page 78)

ARCHITECTS' MODEL OF THE SCHOOL

The new Nightingale School of Nursing, owned by the Province of Ontario, sponsored by the Ontario Hospital Services Commission and operated by its own board of trustees, is under construction at present. The $1,170,000 building is being erected on land donated by the New Mount Sinai Hospital, in Toronto, and is to be completed in 1962. The school, designed by Craig, Madill, Abram and Ingleson of Toronto, will provide accommodation for 138 resident students.

The first two floors will provide space for administrative and academic areas. Each of the next six floors will have 23 individual rooms, a common sitting room, kitchenette, bathrooms, washrooms and toilet facilities, linen room, utility rooms, and a sewing room or small laundry.

On the first floor a sunken lounge, dining and recreation rooms will overlook a paved terrace to the west. Also on the first floor will be the resident director's suite and office, and a medical suite.

Around the central service core on the second floor will be a library, demonstration room, four classrooms, science laboratory, staff and administrative offices. Other service and mechanical needs will be located in the basement.

Two stairways and two elevators will serve all floors. Hermetically sealed double-glazed windows will be used in the main entrance foyer, lounge, dining and recreation rooms. Special precautions are being taken with interior partitions to reduce sound transmission between adjacent rooms.

(See also page 78)

proposed:

A College of Nurses

Helen G. McArthur,
Toronto, Ont.

IN RECENT years nurses' associations, nationally and provincially, have sought new ways to interpret the problems facing nursing in Canada today. They have sought informed opinions from related professions and official and voluntary agencies concerned with health, education and social welfare. The first Canadian Conference on Nursing was called by the Canadian Nurses' Association in November, 1957, for this purpose. A review of the report of that Conference indicates that there were no ready solutions; but some of the opinions recorded at that time have become signposts for sound future planning. There was a strong plea for improved intercommunication and understanding between personnel concerned with the provision of nursing care. With this end in view, a wide variety of provincial and local conferences have followed. To meet this purpose, also, it is my rather difficult task to outline the concept of the proposed College of Nurses. It is difficult to discuss something that does not exist and will only come into being if and when the proposal or concept takes form through a law passed by the Ontario legislature.

A brief review of the events leading up to such a proposal may shed some light on why a new pattern for nursing legislation is being studied at this time. The general factors of a rapidly expanding economy, a growing population, the advent of hospital insurance, rapidly changing patterns of medical care, are some of the reasons for a new look at our standards of education and practices. In addition, in Ontario there is the unique situation concerning nursing legislation. Unlike other provinces in Canada, in Ontario there are at present two acts in force governing nursing education and practice; The Nurses' Registration Act of 1951 administered by the Registered Nurses' Association of Ontario and the Nursing Act, 1951 administered by the Nursing Branch, Department of Health. The responsibilities of the Ontario Hospital Services Commission have also been added.

In 1959, the executive of the Registered Nurses' Association of Ontario was instructed by its membership to seek further legal rights, namely the approval of schools of nursing in Ontario. This privilege is the major statutory power still retained by the Department of Health in the Nursing Act of 1951, at which time the Registered Nurses' Association of Ontario became the registering body for nurses. When the request was presented to the Minister of Health he made an alternative proposal of a new and more comprehensive act to bring together all legal aspects of nursing education and practice. The Act would provide for a new statutory body, now identified as the College of Nurses, to administer the Act.

The name has caused some confusion. It has been frequently pointed out to those concerned and in the press that a college in this sense is not a school or institution but carries the dictionary meaning of a body of people set up for a common purpose and having special rights and privileges; in this case, registered nurses set up by law to administer a statute or act. This use of the word "College" has had an acceptable history in the world and has been used by the healing professions, in particular the College of Physicians and Surgeons which concerns itself with standards of medical education and practice but does *not* conduct schools of medicine. It is proposed that an act establishing a College of Nurses would replace the two 1951 Acts and so bring under one statutory body all legal aspects of nursing. Regulations would be prepared later, after the Act became law, subject to the approval of the Lieutenant-Governor in Council. Thus the statutory powers given to the Registered Nurses' Association of Ontario in 1951, which included the admission standards of schools of nursing, curriculum, examinations, registration and discipline and the function of approving schools of nursing, *i.e.* helping schools to implement the curriculum which was retained in 1951 by the Nursing Branch, Department of Health, would become the responsibility of this proposed new statutory body or College of Nurses.

Helen McArthur, Reg.N.

I am certain you are aware that in the intervening years since 1951 the working relationships between the Registered Nurses' Association of Ontario and the Nursing Branch have been excellent; but the authority has been divided and there has been, of necessity, some overlapping of function. Also there has been some confusion through the schools of nursing not understanding the exact lines of communication. Both groups have recognized the desirability of bringing under one statutory body all legal aspects of nursing and this formed the basis of the approach

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The author is chairman, Working Party on the College of Nurses, Registered Nurses' Association of Ontario. Miss McArthur is also national director of nursing services, Canadian Red Cross Society.

LEADERSHIP

in nursing administration

1. What Opportunities?

Ellen C. McLean,
Toronto, Ont.

BEFORE we examine our situation to discover what opportunities we can provide the graduate nurse for growth in leadership, we must have a clear cut picture in our own minds of why we need to encourage the development of leadership abilities and potentialities in graduate nurses.

In this scientific age machines have replaced humans at many levels in the hospitals. All along the line we are replacing muscle power with brain power. Hospital staffing of today shows little resemblance to that of fifty years ago. Then you could count on one hand the employees of a hospital who could not and did not give care to patients, in addition to doing the cleaning, the laundering and the cooking. Two world wars, with attendant strain on the nursing personnel required, plus scientific advancement, have changed the picture in hospitals. Have we given serious thought to the change? Have we accepted the change?

Using the hospital organizational charts of yesterday and today as our pictures, what changes do we see and what have we done and what can we do about the changes which have affected the nursing staff so greatly?

In today's chart, at the top of the picture, we see that business administrators have taken over from nurses the overall management. At the bottom of the picture we see that the cleaning, the laundry and the dietary staffs with their various machines, have taken over the specific duties. A little farther up the picture we see an inclusion, that of other auxiliary nursing staff, the certified nursing assistant, the nursing aid and the male assistant or orderly, all performing patient care.

Where do we see the nurses now? If something is put in at the top and something is put in at the bottom, one would be inclined to say nurses are in the middle with fewer duties, therefore we need fewer nurses. That is a simple solution to the nurse shortage, isn't it? It is not quite as simple as that, nor is it true. Nursing has had its turn at "taking over" as well as "giving over." In the yesterday's picture, we do not see nurses giving intramuscular or hypodermic injections, taking blood pressures or even taking temperatures. These were the doctor's duties; they were considered medical duties.

The "team nursing" concept and its variations, which for economic and staffing reasons has been instituted, may put the nurse in a less pleasant place in some patients' minds. She, as the person responsible for medications and treatments, has become "the painer" while the subsidiary staff, for whom she is responsible, has become "the comforter", being the one who gives the bath, the back rub and makes the bed. Although nurses may feel they have lost the advantages which the periods of intimate care gave them to learn about the patients' social problems —which so frequently effect a patient's recovery—they have gained infinitely more than they have lost. It is to the nurse the patient turns when in pain or distress. Her stature is greater, therefore her responsibilities have increased accordingly.

On one hand the nurse is performing duties which were formerly medical, on the other she is working with personnel with less preparation than herself and for whose work she is responsible. What can we do to help her prepare

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The author is director of nursing, Northwestern General Hospital, Toronto, Ont.

The following three articles are from a symposium presented at the Ontario Hospital Convention, October, 1960.

2. How to Motivate?

M. Jean Dodds,
Toronto, Ont.

THIS topic is one which has concerned many of us and one which is not readily answered. Mary Parker Follett summarizes her philosophy by stating that, "any enduring society, any continuously productive industrial organization, must be grounded upon a recognition of the motivating desires of the individual and of the group . . . to the end that every individuality may be mobilized and made to count both as a person and as an effective part of the group and of society as a whole."[1]* This of course is true, but herein also lies a difficulty. Due to the fact that each organization and each society is composed of individuals who react differently, rules cannot readily be set down. All we hope for is a guide to assist in the task of motivating graduate nurses to become leaders. A leader is, and I quote, "one who can energize the group, who knows how to encourage initiative, and how to draw from all what each has to give."[2] How can we develop methods to promote this?

The first goal of the professional nurse, theoretically and practically is to give a high level of nursing care to patients; to direct others who contribute, to do likewise within their scope; to develop personally and professionally and to receive job satisfaction.

Assignment and Orientation

We should begin to assist the nurse when she is appointed to the staff, by giving a good orientation. Orientation is often interpreted to be an introduction to the physical set-up of the hospital. While this is necessary, caution should be used, because a detailed tour of a new hospital on the first day serves only to confuse new staff members. Orientation has a much broader meaning dealing with an explanation of the facilities and methods of procuring them; of the policies and practices of the hospital; and of the services available. If there is a school of nursing in the hospital, the program should be outlined, and the relation between the aims of the school and the objectives of nursing service shown. By explaining these early in the new graduate's employment, she will feel that we are desirous that she become an integral part of the hospital and not just "another nurse to increase the staff."

Little will be gained, however, if we stop here. The new and longer term staff members need to continue to feel necessary, and sense that we are interested in them personally and professionally. One or two people cannot possibly give the personal attention required, to a large number of nurses. It takes the co-operation of all working together to accomplish this. The head nurse is a key person in this area. She sets the tone of the ward, and by and large, her example will be followed by the staff. If she welcomes the new member and helps to make her feel a part of the ward, other members will do likewise. This process should be reciprocal, for head nurses, supervisors and instructors also need acceptance and co-operation of the various members of staff.

Communication

Communication is an essential part of any group, and to achieve satisfactory results is a two-way process between nursing administration and the staff. Can we hope for communication *from* our staff unless we have the interest, concern and confidence to communicate *to* them? Face to face communication is the most desirable but several other forms are also useful. Messages may be given through the nursing service supervisor to the head nurse, who records them in a ward "message book" which each nurse is expected to read daily. Memoranda sent to every department, posted on the bulletin board until all have read and initialed them and then filed in the memoranda book, are of value, because they are available for reference when needed. Announcements made at staff education meetings have limitations because a percentage of the nurses, on night duty and days off, will be absent. A news letter may be distributed at intervals to forecast changes which are taking place.

Lines of Communication

Communication *from* the staff can best be handled by the nurse discussing her suggestions directly with her immediate senior, who will in turn, discuss them with the person to whom she reports. It is important that the organizational chart be explained to the staff and available to them so that they will follow the lines of communication as far as possible. It is equally important that a staff member feels that she has the privilege of asking for an appointment with an assistant director or

The author is acting director of nursing, Toronto General Hospital, Toronto, Ont.

**For references see page 82.*

the director of nursing. The matter may be one which she wishes to discuss in a direct, personal or confidential manner. The request of the individual should be respected.

Relationships

The ability to communicate with one another helps to establish personal relationships. When these are good, there will be harmony on the ward, incentive, greater job satisfaction and motivation to do more than the essentials. Human relationships are not confined to the ward, or to the nursing department, because neither of these is self-sufficient. Inter-departmental relationships are of vast importance, and it is the responsibility of each one to establish good rapport with other departments. If this can be accomplished, these other departments will look to nurses for leadership, and nurses will accept this rôle, and achieve satisfaction in understanding human beings and establishing warm relationships.

Participation

Participation of staff in meetings, conference, discussion groups and so forth, is often difficult to accomplish. It is easier to "let someone else" do it, but once the participant has become involved, she usually develops an interest and makes a good contribution. The difficulty lies in first arousing this interest. Perhaps we in administration need to look at ourselves! Do we present the task at hand with sufficient enthusiasm? Do we make it sound challenging enough to arouse interest? On the various nursing education and nursing service committees, there should be representation from all groups—head nurses, supervisors, instructors, general staff nurses, students and nursing assistants. This tends to give a happy balance between nursing service and nursing education, with each realizing the other's functions and each working together toward the common goal of better patient care.

Nursing is the senior profession in the field of health. It is our responsibility to maintain this position by accepting leadership and preparing others to do likewise. By various methods, we should stimulate graduate nurses to participate in nursing beyond their daily duties, *i.e.*, to be informed about the broader scope of nursing. Douglas Peart, administrator at the Ottawa Civic Hospital, said in a recent article, " . . . nursing belongs to nurses, and assistance, co operation and respect is required from hospital administration toward the profession. The reverse of course is also true . . . ".[3] If a job-analysis is undertaken to determine the duties of various groups within the hospital, we could eliminate non-nursing duties and leave nursing to nurses.

Staff Education

The staff education committee should be responsible for an in-service program for graduate nurses. Topics presented at these meetings will vary, but basically should be directed toward better nursing care through presentation of new developments in medicine and surgery; new procedures in nursing care; or presentations by other members of the health team by means of panel discussions. Members of other health agencies may be invited to present their work. Participation by nurses other than instructors and supervisors should be encouraged, for the latter are so often the leaders. Post-basic study in nursing education, nursing service administration or public health nursing should be encouraged as preparation for qualified leadership.

Within various nursing specialties too, an in-service program is invaluable. Staff nurses and doctors can develop a teaching program designed to assist the nurse to develop her ability to give skilled nursing care. This should help to give her the motivation necessary to do additional reading and studying. Every nurse is a health teacher—a teacher of patients, student nurses, other graduates and auxiliary personnel. Often she does not see herself functioning in this capacity. We need to help her in this rôle of teacher, for a graduate nurse should participate in health teaching.

M. Jean Dodds

Evaluation

A system of evaluation of the graduate nurse proves to be beneficial to nursing administrators and to the nurse herself. Too often in the past, there has been a tendency to point out to the graduate nurse her mistakes, but not to discuss her general performance. This should be a learning situation, not just a time for criticizing. Strengths as well as weaknesses are discussed and we have found that the staff appreciate this. Let us be generous with time and praise, impartial and objective. Most people like to be given credit for good performance, and will respond to correction if it is given objectively, fairly, and by an evaluator for whom they have respect and whose opinion they value. We do not reserve evaluations for general staff nurses only. All graduates have been evaluated—head nurses, instructors and supervisors. We believe that everyone responsible for evaluating another, should herself willingly be evaluated. The records become helpful when considering staff for promotion, and when writing references on a nurse's behalf. Promotion should be based on merit, and not merely on length of service. Experience of the right kind is invaluable, but the development of right attitudes, and growth of the individual are factors in merit, and ingredients of success.

Attendance at conventions and conferences is a professional responsibility and should be encouraged. Hospitals should send as many delegates as possible, so that information concerning our provincial and national associations will be available to as many as possible through actual participation, even though the news is eventually reported in various publications. To be present at such meetings, provides stimulation for all, and brings the participants into contact with women who are leaders in our profession. Attendance and participation at conferences which make use of group dynamics, assists members to give thoughtful consideration to the affairs of our profession. Nurses who are in

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3. When to Motivate?

Sister St. Louis, C.S.J.
Sudbury, Ont.

BEFORE giving a definite answer to this question, I would like to qualify the nature of motivation as I see it. Motivation, here, will be referred to as (a) remote, (b) proximate, and (c) immediate.

Motivation which is classified as remote would begin the first year, as soon as the preliminary student makes her first professional patient contact. Although this motivation may be termed subconscious, in that the student is unaware of its activity it is none the less real. At the 17-year-old hero worship age, the student finds herself automatically imitating, idealizing, striving to resemble the calm, efficient, all-seeing, all-knowing head nurse who is present to introduce her to her first real patient, to direct her confused steps to the linen room, to smile understandingly at the struggle when the student reports on or off duty in that first awesome hour of patient care. This initial motivation, then, is indirect, is unconscious in that it is not necessarily planned, is enthusiastically inspirational, and because of its vivid nature, is lasting.

In my thinking, proximate motivation begins in the senior year. At this time, the student reaches her peak—in skill, in confidence, in sense of purpose and direction. The school of nursing could take definite steps to create opportunities and circumstances which will provide incentive for leadership. Managerial and social service skills may be developed by carefully planned discussions, demonstrations, by actual contact with good supervisors and head nurses who know their functions, who are interested and successful, and who have good relationships with administrative and medical staff.

Formal classes given to senior students could include topics such as administration, supervision, lines of authority, job analysis, communication, community health. Various persons, such as the hospital administrator, the director of nursing service, the psychologist, the social worker, the ward supervisor or head nurse would take an active part in the presentations. Incentive for professional growth would be derived also from group activity such as surveys of postgraduate and university courses available, interviews with university graduates who hold hospital positions, questionnaires and assignments to test the level of understanding.

Application of this learning experience would be planned in the clinical field, where senior students who have displayed leadership qualities may be selected for additional experience. Under adequate supervision, the senior student may assist the head nurse or clinical teacher, thus sharing the administrative and educational activity at close range. While working under the direction of the nursing arts teacher, the senior student supervises, guides, evaluates the performance of a preliminary student. This experience provides a refresher in basic practice, since nursing must be re-learned before procedures can be supervised. The nursing service experience, under the guidance of the head nurse, gives opportunities for interdepartmental contacts, medical referrals, and follow up of patient care. In this manner, the student develops the ability to exercise skills under close supervision, with moderate experience of success and satisfaction. Thus sufficient incentive is created to stimulate interest in future study in the field of her choice.

The proximate motivation as planned for the senior student in the classroom is considered to be direct, group motivation. In the clinical field, motivation would be on an individual basis.

There may be the danger present in some senior who is immature enough to feel that after one year of bedside nursing, she is thoroughly prepared to undertake university administration studies in order to qualify as nurse administrator.

For this reason, immediate, individual motivation should be planned for the graduate nurse. This nurse must be selected carefully, as a person who is more interested in becoming rather than in knowing. She should be a well-rounded individual, capable of fulfilling her needs for effective living, a contributing member of society in addition to being a contributing member of a professional group. She ought to have knowledge of human behaviour as well as technical skill, and she should be a person who has elasticity of judgment, who can accept the responsibility of her own decisions and

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The author is director of nursing, Sudbury General Hospital, Sudbury, Ont.

GUELPH GENERAL HOSPITAL SCHOOL OF NURSING

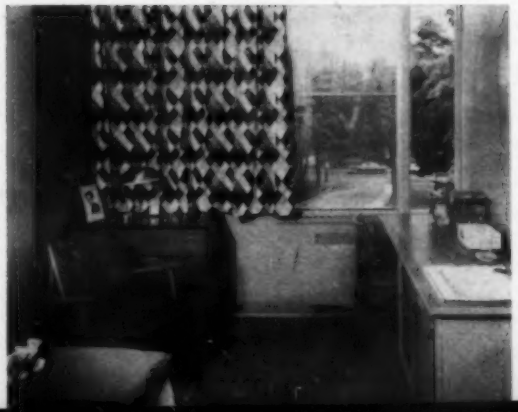
designed for study privacy and relaxation

THE NEW nurses' residence and school at the Guelph General Hospital, Guelph, Ontario, completed late in 1959, is of unusual and highly successful design. (See *Canadian Hospital*, April, 1957 for plans by Craig and Zeidler of Peterborough and Toronto.) The buildings provide accommodation for three contrasting activities—quiet bedrooms and their subsidiary facilities, a centre for social gatherings, large or small, and a school section. Each avtivity is housed in a separate unit. A multi-storey residence of reinforced concrete flat slab construction is linked by connectors, to a two-storey social centre and a one storey school.

In the residence section single rooms were chosen to provide for privacy. Each room contains a washbasin, closet space, a built-in desk, and bookshelves, designed to give the appearance of a small sitting room. There are 25 rooms on each of the four floors with a common kitchenette and breakfast room, common bath, shower and toilet space. On the ground floor three apartments for supervisory staff with private outside entrances are provided.

The social centre is an oval building separated from both other sections by connectors. A large lecture hall (or auditorium) is situated on the ground floor and the main foyer or reception area is on the floor above. A serving pantry adjoins the lounge which is large enough for group entertainment by the students.

The school section is a centre corridor building, with rooms on each side. Space has been provided for instructors' offices, a health service unit, library, seminar room, as well as a classroom and a demonstration room, each capable of seating 50 students. Three laboratories are provided—each designed for a group of 16 students.



in the small hospital

administrative techniques for the NURSING SERVICE

Kathleen Ruane
Toronto, Ont.

IT HAS been recognized for some time that the physical organization of the hospital, such as the arrangement of the operating room, central supply room, diet kitchen, lighting and ventilation systems, has an effect on the rate and degree of the patient's recovery. Only recently has it been acknowledged that the human organization—the people who do the work and how they do the work—in the hospital also retards or promotes the recovery of the patient.

One of the important functions of administration is to organize. This involves defining areas of responsibility and listing jobs to be done, drawing up a structure of these jobs and assigning appropriate staff to them. One of the basic principles of organization is that of homogenous assignment, *i.e.*, the grouping of similar activities or responsibilities together for allocation to the individual worker. Recognition of this principle tends to foster efficiency and gives the worker the feeling that his work pattern flows in an orderly manner.

Determining areas of responsibility and lines of authority or, in other words, knowing who is to direct whom and who is responsible for what, also has the effect of developing good staff relationships. There should be a unity of command and control all along the line. The span of control should not be so broad as to prevent prompt communication nor should the vertical lines be so long as to lead to misinterpretations.

The organization pattern of a small hospital will differ in some respects from that of a large hospital. But the basic principles will be the same; and the need will be just as great to fix responsibility and control. It is true small hospitals are less departmentalized, less formal, and there is greater opportunity for the personal contact. The duties and responsibilities of any staff member are not as clearly defined in a small hospital and they tend to be more numerous and diversified. The nurse, instead of the doctor, may take x-rays and establish intravenouses. She may admit the patient and discharge him after completing his account in the business office. She may dispense drugs from the pharmacy and prepare the patient's food trays. To organize successfully, it is not what the worker does that is so important but that he *knows what* to do and *does what* he knows.

The author

Communications

Lines of communication, to be effective, must be as direct as possible and should be up through, as well as down through, the organization. In early societies where the structure was simple, problems in communications did not exist. Where a division of labour occurs and men tend to specialize, people must know what to expect of each other and what is each one's responsibility.

Information may be channelled to the various departments through memos, conferences, meetings, reports and manuals. Meetings should be scheduled judiciously so as not to waste time and advance notice should be posted. Agenda should be drawn up with a view to achieving the purpose of the meeting. Encouraging committee members to arrive punctually and calling the meeting to a close on the appointed time are also important items to remember.

Much time can be lost at meetings yet the efforts made to develop the group approach show that much energy is saved and tempers soothed if people, who are affected by a change in policy, have an opportunity to take part in the planning and know what is going to happen. A hostile attitude on the part of employees can undermine the best laid plans.

It is the wise administrator who keeps his ear to the ground for rumblings of discontent or for suggestions that would improve patient care. I would like to use an illustration of communications being directed upward which resulted in improved service to the patient and at the same time improved staff morale. The nursing staff on a unit requested that the patients be discharged at an earlier hour in the day and that the order for discharge be written the day before. This would enable the patient to make suitable arrangements with his relatives, the nurses

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The author is director, Extension Course in Nursing Unit Administration, Canadian Hospital Association.

THE HOSPITAL LIBRARY —

a privilege and opportunity

Douglas R. Peart
Ottawa, Ont.

UNDER the Standards for Accreditation of Canadian Hospitals, a medical library is considered an essential service. Also in our standards of recognized facilities for a good nursing education program, a library is essential for the teaching of student nurses. These standards have been created in wisdom and, in fact, better patient care is achieved through keeping the professional and technical staff of a hospital up to date with current literature.

Not Deemed Essential

Of a paradoxical nature, however, is the fact that the patient in hospital probably has much more time to read than either the doctor or the nurse; and yet for various reasons, a library service for patients is not considered essential. Even so, we are continually talking today of treating the whole patient. On this thinking alone, a library service is very important in providing diversional therapy and recreation for patients. This has most certainly been the experience at the Ottawa Civic Hospital—which has had a library service run by volunteers since the institution was first opened in 1924. In fact, a hospital library service for patients in the City of Ottawa goes back to the year 1904 in the old St. Luke's Hospital, which went out of existence when the Civic Hospital opened.

The author is administrator, Ottawa Civic Hospital, Ottawa.

The May Court Club of Ottawa

Credit for this long and outstanding achievement of library service is rightfully due to the May Court Club of Ottawa. This club was founded in 1898 by Lady Aberdeen, wife of a former Governor-General, and a small group of ladies who organized themselves for the purpose of helping others in less fortunate circumstances. Quite apart from the library service at the old St. Luke's Hospital and subsequently the Ottawa Civic Hospital, the May Court Club operates an anti-tuberculosis program and a convalescent home in Ottawa. There are at present 450 women who make up the membership of the club. In joining, each member must volunteer to contribute a minimum amount of time in one of the club projects, such as the library service for patients at the Ottawa Civic Hospital.

Organization

Over the years since 1924, the library at the Ottawa Civic Hospital has grown under the May Court Club Library Committee, which has 35 active working members made up of three sub-committees as follows:

1. The Circulation Committee, consisting of 22 members who make rounds with a cart once a week to all patients and distribute or exchange books in accordance with the need of patients.

2. The Magazine and Book Collecting Committee, consisting of six members who are responsible for collecting magazines, books and other types of literature within the community, and delivering the publications to the library at the hospital. Much of the reading material is donated by May Court Club members, some from friends of the hospital and frequent donations of periodicals and paperbacks are made by distributing agencies in the trade.

3. The Utility Committe, consisting of seven members who meet at the hospital one evening a week to assist with clerical jobs, cover new books, recover old books and generally maintain the reading material.

Distribution of Volunteers

The library began with a nucleus of 600 books which were donated from many different

The ladies in action.

sources. Over the years the total number of volumes has increased to 7,000 which are now kept in several hospital areas. It will be appreciated that the Ottawa Civic Hospital is a 1000-bed institution with patients in three separate buildings. Although the basic depot for books is the recognized library centre in the main hospital building, the May Court Club has also been given a smaller room in the Veterans' Pavilion of the hospital for ease in distributing books to veteran patients. Similarly, in the East Lawn Pavilion, which is a 70-bed building on the hospital property, book shelves are arranged in the sunrooms and stocked with May Court Club books for the convenience of patients in the building. The paediatric department is also served with shelves containing comics and children's books, which are replaced regularly by members of the Circulating Sub-Committee.

Financial Donations are a Help

It is of interest to record that one of the local high schools, wishing to create a memorial to former students and teachers who died in World War II, agreed in 1944 to donate an annual amount to the May Court Club for the purchase of books for the veterans' pavilion. Other donations have also been received to perpetuate the library. The most significant was contributed by the former librarian, who served the patients of the hospital in a most dedicated way from 1924 until she died in 1955. She left the bulk of her estate to further the interests of the library.

The monies available through donations allow for the purchase of approximately 150 new books a year and the purchases are made by the professional librarian, who handles the general organization and is, of course, a member of the Library Committee and all sub-committees.

New Volumes

It should be recorded that books are not purchased daily but only four times a year. A very careful selection must be made because the money available is approximately $600.00 which must be spent in the best interests of all concerned. Accordingly, the professional librarian runs a perpetual book list and constantly reviews further lists of best sellers as published from time to time in newspapers.

Books are all purchased from local suppliers who tend to give substantial discounts for worthwhile causes. In addition to books which are purchased by the professional librarian through allotted monies, a reasonable number of other new books are purchased privately and donated to the library.

Reading Habits

Reading habits are also of interest insofar as fiction accounts for a large portion of the books handled by the library and non-fiction about 25 per cent of the total volume. Some patients are most prolific readers and probably the record is 160 books read by a patient in one month. Many others are able to read as many as six books a week.

Circulation

In addition to patients, the library is also open to the hospital staff on a basis of twice monthly. In a large hospital with approximately 2,000 employees, it may be recorded that the circulation of books to staff is approximately two-thirds of the circulation to patients. In this connection approximately 700 patients are visited weekly by members of the Circulating Committee and probably three-quarters of all patients are interested in reading material in one form or another. Only about thirty per cent of patients are interested in hard covered bound volumes and the others take mystery thrillers, magazines and comics. Out of 7,000 hard covered volumes now available in the library, significant is the fact that probably only 3,500 volumes have a regular circulation. It is typical of most libraries to have a number of books which may be dated or obsolescent, or just not popular among certain readers. Even so, by way of calculation, each patient accepting books takes on an average of two books a week, which means a distribution of probably 450 volumes a week or over 20,000 volumes a year. Considering that the staff also participate on a two-thirds basis, then the 3,500 books in active circulation are distributed to a total of approximately 33,000 readers in a year. This is quite apart from magazines and other miscellaneous types of literature.

Disappearance

It will be appreciated that some books go out of use each year, through lack of popularity or because they are worn out or lost. All books are covered by the Utility Sub-Committee and are stamped to identify library ownership on the inside cover. The stamp appears also on the back cover and various places throughout the book. Even with the stamping, some patients are inclined to take books home, and from time to time, student nurses may take books to the residence. Also, new patients may be given books by the staff on the floor and all these possibilities add up to a minor problem in keeping track of books. However, the main purpose of the library is not affected to any great degree by the loss of books. In fact, missing books are often found to be temporarily mislaid and, by and large, they are returned to the library.

The library is under a professional full-time librarian, who is employed by the May Court Club of Ottawa and, simply to have a stake in the program, the Ottawa Civic Hospital provides a very small stipend of $200.00 a year towards the salary of the librarian.

Through Experience

Much of the literature dealing with library services for patients suggests a central location with good lighting, tables for reading

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in nursing administration

ECONOMIC ASPECTS OF STAFFING

Mrs. Isobel MacLeod,
Montreal, Que.

THERE ARE many conditions in present-day society which make it more expensive than ever before to hire any kind of worker. They are such well known conditions as generally higher salaries to keep pace with the rising cost of living, a shorter work day and a shorter work week. These have had their effect on the economy of nursing, too; but there are some other changes which, in recent years, have contributed directly or indirectly to the rising cost of maintaining a nursing service. I have grouped them under four main headings—the high rate of patient turnover, the high rate of nurse turnover, problems in the suitable use of the nurses' time, and changes in medical practice.

Patient Turnover

Using the figures of one general hospital which might be considered typical, I find that over the past 20 years the average length of stay for a patient in hospital has decreased by 2.6 days. This means that a great many more patients can now be admitted to a given number of beds in a year. This is one of the many situations in hospitals today which means more work for nurses. More work means more nursing personnel and more money.

On the nursing unit today, there is a constant flow of patients in and out. Even though some of the admission work has been delegated to other workers, the nurse must greet the new patient, explain what will happen to him, see that the doctor is called, assist him with the examination, prepare him for tests or operation, and see that medications are started—only a few of the duties connected with admissions. On discharge, his medications, dressings, et cetera, must be gathered together, last minute instructions must be given and someone must be found to take him down to the door while the next patient is waiting for the nurse to begin the admission procedure again.

Previously, the patients who were considered to be seriously ill stayed in hospital for a longer part of their convalescence. This meant that the nursing unit had part of its population in need of little more than custodial care. Today practically all short-term patients are either fresh post-operatives or acutely ill medical cases requiring constant treatment, nursing care and supervision, or a variety of tests.

Closely akin to the rapid turnover is the high occupancy. With most hospitals now running at close to 100 per cent occupancy (or even more), much nursing time is spent moving patients to accommodate the requirements of the admitting office. Rearrangement of beds is constantly necessary to move patients from room to room and place the only vacant bed in a male instead of a female ward. When this bed is filled and an emergency patient arrives, he is squeezed into another unit of a different service. The next day there is still more moving to get the emergency admission of the night before into the right place. It is unnecessary to say anything of the additional demand on the nurse's time caused by caring for patients admitted as emergencies into rooms not intended for patient care.

Turnover of Staff

Over the past two decades, the turnover of general staff has increased tremendously, especially in recent years when the airplane has made it possible for people of moderate means to travel much more extensively. Before the second world war, it was common for a nurse to spend most, if not all, of her professional life in one institution, frequently the one from which she graduated. Now this is the exception among young general staff nurses. Like their friends in other occupations they want to see the world and find they can finance it by working their way through the countries of their choice. Of this group I think it is safe to say that few stay in a hospital longer than 12 months. This means that to fill a position which once would have been occupied by one nurse for three years, three nurses have to be introduced. This costs the time of supervisory staff and causes a loss of efficiency.

Most large hospitals now find that they are obliged to provide an orientation program which goes on constantly with group conferences and demonstrations. This usually takes much of the weekly time of a supervisor. Add to this the time required to appoint this changing staff to wards and you see that the full time of a member of the nursing office staff is absorbed. Formerly, staffing the wards was just one of the many other activities of the director of nursing or her assistant. I have not even mentioned the very great increase in administrative time spent in correspondence with applicants, giving and asking for references, and holding interviews.

And a great deal of time is occupied in meeting the adjustment problems of this migrant staff. It might be argued that travel is the choice of nurses and, therefore, it is not our concern if they are lonely and able to find only poor and depressing accommodation. Yet as members of a profession which

(concluded on page 72)

Mrs. MacLeod is director of nursing at the Montreal General Hospital, Montreal, Que. She gave this paper at the annual convention of the Quebec Hospital Association, March, 1959.

ECONOMIC REWARDS

in the nursing profession

Bernard McCarthy
and
James Maxwell
Toronto, Ont.

THERE are two sides to every question and the matter of pay scales for nurses is no exception. At least once each year most hospital administrators are confronted with this question through the necessity of obtaining or retaining nursing staff and occasionally it becomes the subject of public discussion in such media as the "Letters to the Editor" columns of our daily newspapers. Here we see strong positions taken by both sides, those who believe that nurses are grossly underpaid, and those who think the opposite. If such expressions were taken as a poll, the proponents of more adequate pay for nurses would appear to be in the majority, but there are a few vociferous dissenters whose beliefs are typified by this quotation from a recent letter to the Toronto Daily Star. The writer under the pseudonym, "Disgusted", says, "Nursing is the only profession that pays for the board of its students while they are in training. The student nurse only has to pay for her uniform, books, et cetera. Can you name any other profession which does this, and practically guarantees $12.00 a day to start?" This correspondent contends that clerical workers rather than nurses are the most underpaid of any group.

Unfortunately proclamations such as these shed little light on the question; and one wonders if there is not some objective means of determining a reasonable rate of reimbursement for nurses through comparing their pay scales with those of other occupational groups in our society.

Traditionally nurses have compared themselves with teachers, with elementary school teachers in particular, and there is some justification for this. Both professions have many characteristics in common. They are the so-called service or helping professions and women are dominant in number in both. The entrance requirements are average, academic fees are small, qualifying periods are reasonably short and the skills acquired in each are durable, portable, and have wide social utility. The majority of practitioners in each are salaried.

With so much in common it is understandable that these occupations would be compared and it is natural to extend this comparison to economic rewards. In this respect many nurses are convinced that they fare very poorly and it is timely therefore that we look more closely at the monetary return from these occupations in relation to the expenditure of time and money required to qualify for each. Certainly it would be very mundane to consider education *only as a monetary investment*, but this aspect cannot be ignored entirely. In our competitive economy students, in choosing careers, do look at future earnings, at monetary as well as other job satisfactions. Careers which appear to be seriously deficient in any of these aspects cannot hope to attract and retain the attention of today's discriminating youth.

A Basis for Comparison

By comparing the rates of pay for these jobs with the corresponding student expenditure to become qualified, we can obtain a picture of their relative attractiveness as an investment. And despite the limitations of such a comparison there are several precedents for it. For example both federal and provincial governments recognize in their pay structures that there is a cost for additional education and offer, in some jobs, higher starting rates for advanced academic qualications. In the practice of medicine also we see similar recognition of the cost of special training. In the schedules of fees suggested by medical associations higher fees are recognized for surgical procedures performed by specialists.

Who would dispute the reasonableness of a system used by these groups and already accepted in broad areas of our society?

Expenditure

To calculate and compare the expenditure required of a high school graduate who aspires to a career in nursing, elementary school teaching or high school teaching, one must consider such factors as academic fees, cost of maintenance, loss of income, and vacation earnings. These may be expressed by the following formula:

Student Expenditure = By + Fy + (Ly — S) where

B, board and lodging estimated at $1200 per year.

y, years of training after completion of Grade XIII[1].

F, academic fees per year[2].

L, loss of income estimated at $2400 per year[3].

S, summer earnings estimated at $200 per month[4].

Substituting in this formula we find the student expenditure for each of these occupations to be:

Nursing
$(2 \times \$75) + (2 \times \$2400) = \$4{,}950$

Public School Teaching
$\$1200+\$25+(\$2400-\$400)=\$3{,}225$

High School Teaching
$(4\times\$1200)+(4\times\$350)+4\times\$2400 - (4 \times 4 \times \$200) = \$12{,}600$

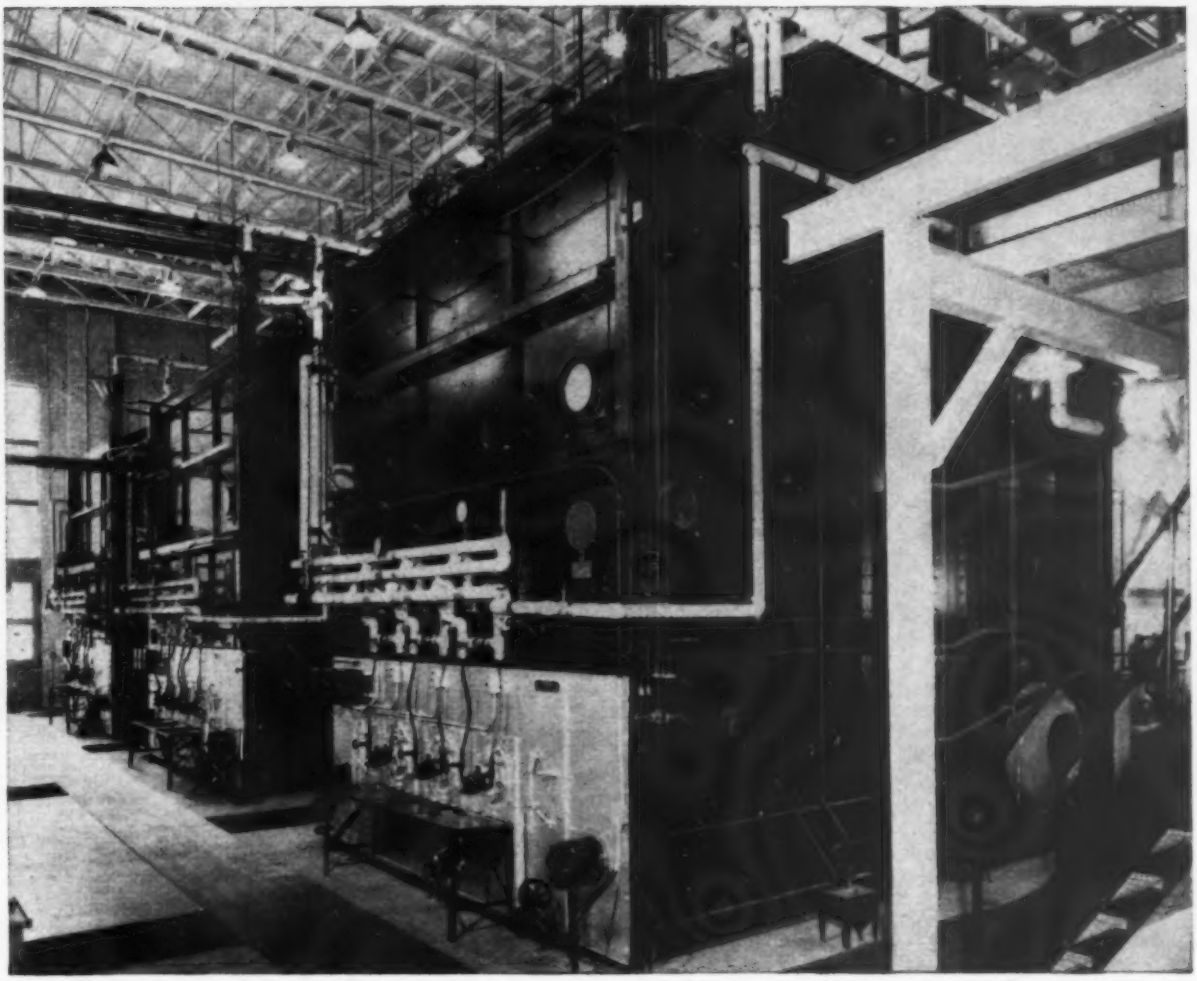
Rates of Pay in Toronto 1961

Because wage rates and salaries vary considerably with location we have confined our comparison to one community, the City of Toronto. In January, 1961, the annual starting rate in Toronto hospitals for registered nurses, with minimum qualifications and without experience, was $3,420. At the same time the Toronto Board of Education had the following rates in effect for teachers with minimum qualifications and without experience: public school teachers (Category 1) $3,300, and high school teachers (H.S.A. Type B.) $4,500.

Through annual increases of $120

Mr. McCarthy is administrative assistant at the Ontario Hospital Association. Mr. Maxwell, a recent graduate in Political Science and Economics from the University of Toronto, employed in a temporary capacity by the O.H.A., collaborated with Mr. McCarthy in preparing this study.

For references see page 56.



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per year a general staff nurse may attain a rate of $3780 after four years. Annual increments for teachers are $300 for the first two years and $200 for subsequent years. For the elementary school teacher seven annual increments are provided, to a maximum of $4,900. For the high school teacher, there is provision for 15 annual increases to a maximum of $7600 per year. By way of comparison with nurses and teachers, a grade XIII graduate without specialized training could expect a starting rate of $2,400 in 1960. Such a position will normally provide for an annual increase of $150, or a top rate of $3,000 after four years.

Return on Investment in First Year of Employment

In calculating the return to nurses and teachers for education beyond grade XIII we must deduct the estimated earnings of the grade XIII graduate. This is the basic educational level for entry to the nursing and teaching courses, hence these earnings are not attributable to further investment in education.

When $2400 is deducted from the starting rates for nurses and teachers we find the following net returns from the practice of these occupations in the first year:

Nursing	— $1020
Public School Teaching	— $ 900
High School Teaching	— $2100

Relating these net gains to the additional expenditures required we find percentage returns as follows:

Nursing

$$\frac{\$1020}{\$4950} \times 100 = 20.6\%$$

Public School Teaching

$$\frac{\$\ 900}{\$3225} \times 100 = 27.9\%$$

High School Teaching

$$\frac{\$\ 2100}{\$12600} \times 100 = 16.7\%$$

Public school teaching thus offers a higher initial return for investment in further education than does nursing, and is more attractive initially than high school teaching.

Return on Investment Over Five Years

This is the situation at the end of the first year, but since nurses and public school teachers generally practise their professions about five years before interruption, let us see how the returns compare over five years of employment. Considering annual increases, gross incomes over the first five years are as shown in box. Similarly the total income for the grade XIII graduate over the first five years is: $2400 + $2550 + $2700 + $2850 + $3000 = $13,500. Thus the net returns from nursing and teaching over the first five years are:

Gross Incomes Over First Five Years

Nursing	— $3420 + $3540 + $3660 + $3780 + $3780 = $18,180
Public School Teaching	— $3300 + $3600 + $3900 + $4100 + $4300 = $19,200
High School Teaching	— $4500 + $4800 + $5100 + $5300 + $5500 = $25,200

Nursing

$18,180 — $13,500 = $ 4,680

Public School Teaching

$19,200 — $13,500 = $ 5,700

High School Teaching

$25,200 — $13,500 = $11,700

These returns in relation to investment are:

Nursing

$$\frac{\$\ 4680}{\$\ 4950} \times 100 = 94.5\%$$

Public School Teaching

$$\frac{\$\ 5700}{\$\ 3225} \times 100 = 176.7\%$$

High School Teaching

$$\frac{\$11700}{\$12600} \times 100 = 92.9\%$$

Conclusions

From these calculations it is apparent that nurses receive a lower rate of return from investment in additional education than do public school teachers. This is true both initially and over the first five years of practice. The difference in favour of teaching increases with time. In relation to the expenditure required of the high school teacher to attain minimum qualifications, the rate of return to the nurse, both initially and over five years, is comparable. But, although nursing and high school teaching provide a lower rate of return on investment than does public school teaching, the expenditure required for these occupations appears to be a sound investment.

In these calculations we have not considered the possibility of teachers obtaining additional income through summer employment. This opportunity does not exist to the same degree for nurses. The present supply of nurses is such, however, that they may have more opportunity of obtaining casual employment in off-hours than do teachers. Also omitted from these calculations is the effect of our income tax structure on such factors as educational expense and disposable income. Consideration of these factors, as well as changes in any of the conditions outlined, could alter the relationships described.

References

1 Public School Teaching, 1 year, Nursing (Nightingale School, Toronto), 2 years, High School Teaching Type B Interim Certificate, 4 years.

2 Public School Teaching (Ontario Teachers' College) $25.00, Nursing (Nightingale School, Toronto) $75.00, High School Teaching (University of Toronto, and Ontario College of Education) $350.00.

3 Based upon government and independent wage surveys conducted in 1960, $200 per month is the average starting rate for a High School Graduate (Grade XIII) employed in clerical work in Toronto.

4 The candidate for elementary school teaching has a two month vacation in one year, and the candidate for high school teaching has a four month vacation in each of four years. ■

News from Antigonish

The St. Martha's Hospital in Antigonish, N.S., can report an interesting list of activities carried on at the hospital in recent years. A union has been established at the hospital for the past four years and the relations with union officials have been favourable during this period. At the present a two year contract has been signed so that yearly negotiations could be eliminated.

Commencing with January 1, 1961, all hospital employees on payroll are eligible to join the Nova Scotia Pension Plan. The hospital reports that 85 per cent of its employees have already joined the plan.

This year the hospital is planning to begin the construction of a new nurses' residence with accommodation for 140 students and graduate nurses as well as a nursing school, with classrooms, laboratories, a library and lecture hall.

For Fast or Feast: Almost any time proves to be a good time to offer patrons a fish sandwich. Here's one they'll enjoy. It could be a profitable addition to your daily selections. Fry it to golden-crusted crispness with Kraft's Red Label Shortening.

Cheese Scallops

Amount per serving: 9 scallops

INGREDIENTS	24 SERVINGS
1. Egg whites	24 (20 oz.)
Kraft Sharp Cheddar Cheese, shredded	6 lbs.
Dry bread crumbs	3 cups
Worcestershire sauce	¼ cup
2. Kraft Red Label Shortening	—
Kraft PC Ketchup (¼-oz. portions)	24

1. Beat egg whites until stiff but not dry. Fold in the remaining ingredients and mix until well blended.
2. Roll level tablespoons of the mixture into balls and deep-fry in shortening, 325°, for 3 minutes. Drain. Serve with Kraft PC Ketchup.

Ahoy . . . Cheese Scallops: No seagoing experience needed to prepare these prairie scallops. They're made with a good sharp cheddar—Kraft's Elkhorn—and a few simple ingredients. Pop 'em in the fat for 3 minutes. Customers say: delicious! See recipe above.

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Like to increase the *recovery rate* of your fry kettles? *Profit* recovery, that is. Introduce french-fried items that are *new* to your customers. Naturally, these newcomers will give you a better mark-up than your more competitively priced "menu regulars." Try these two recipes . . . and ask your Kraft man for others.

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food service institutes for HOSPITAL COOKS

Joan Groves, B.H.E.,
Victoria, B.C.

AS EARLY as 1958, spurred on by encouragement from the Nutrition Division, Department of National Health and Welfare and an appreciation of this specific need, the Health Branch and the British Columbia Hospital Insurance Service embarked on their first refresher course for hospital cooks.

The object of the course in general was the improvement of food service in those hospitals which do not have a dietitian to supervise the complete food service, to plan therapeutic diets, and carry on staff training. In small hospitals these tasks are usually under the director of nursing who is involved with many other aspects of patient care. It was hoped through institutes to assist the cooks to serve well-prepared attractive and nutritionally adequate meals within their budget allowance, and through discussion, to assist them with their problems. Also, hospital administrators throughout the province had often expressed a desire for some type of training and assistance with the problems of food service in small hospitals. .

The cooks who attended were, in most cases, from hospitals of 100 beds and fewer, the majority having less than sixty. Cooks from small hospitals are a faithful, hard-working group, many of them with years of service to their credit. They, for the most part, are usually housewives whose practical knowledge is their only preparation for the work of preparing and serving meals at their hospital. Some of them step in to fill the breach in an emergency and stay on to serve their community. Few of them have had the advantage of formal training or experience in quantity food service.

Locations

Cranbrook, in the south-east corner of the province, was the location chosen for the first course and the title decided on was Food Service Institute. The Sister Superior of St. Eugene Hospital, who showed decided interest in such a project, helped to pave the way by offering accommodation.

As the first institute was well received and could be termed a success the venture was continued. Three institutes in all were held (at Cranbrook, Prince George and Nanaimo) and the planning was in the hands of the Health Branch nutrition consultant and the B.C.H.I.S. nursing consultant, Elvira Nordlund. Most of the small hospitals in British Columbia were reached, as well as a few homes for the aged.

The response from hospital administrators was good, especially after completion of the first institute; and further contacts with them have shown that they considered the course well worth while.

Federal health grants were applied for and received in all three cases. Without this it would not have been possible to carry out the institutes, especially in a province in which the population is so widespread. Travelling and living expenses for all those in attendance, as well as guest instructors, were defrayed by money from the grant.

In choosing a location, a point which was fairly central for a specified district was decided on although, in the first instance, the interest shown in that area of British Columbia and the availability of such satisfactory facilities was a deciding factor. In parts of British Columbia the only available means of travel is by air so the centres chosen were close to or on a main air route. Air travel was allowed when it was the only means of travel or when the route was very long and round about by other means. People in British Columbia are used to travelling long distances and many cooks from remote areas undertook tiresome trips in order to attend. It was impossible to avoid this and could only have been prevented by having more and smaller classes which, in the long run, would have been much more expensive.

Classes varied from 16 to 26 in number which was satisfactory. A class larger than 25 makes it difficult to discuss and talk over prob-

The author is nutrition consultant, Health Branch, Department of Health Services and Hospital Insurance, Province of British Columbia. The article was submitted by the British Columbia Dietetic Association.

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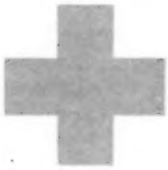

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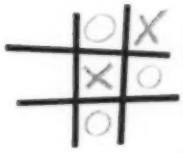

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OFFICES FROM COAST TO COAST

lems and give individual assistance. Discussion seems to take place very readily in a group of that size.

Questionnaires distributed with application forms gave an indication of what hospital administrators considered were problems. The subjects most often suggested were menu planning, therapeutic diets, cost control, and sanitation. As far as the cooks were concerned, they felt their most difficult problems were special diets and menu planning. Many administrators said their cooks, on the whole, were doing an excellent job; others felt that everything was satisfactory except costs. Some thought assistance was necessary in menu planning and variety but in no instance was their lack of skill as cooks ever mentioned. These points plus observations made by consultants in their hospital visits were taken into consideration in planning.

The Course

Classes consisted of lectures, films, slides, demonstrations and discussions. One field trip at least was arranged for each class depending on what was available in that centre which might be of interest. These included: visit to a local dairy, to a new hospital kitchen, or to a meat cutting department of a super market.

The three courses followed the same pattern but naturally there was an attempt to improve as we went along. Experience was valuable and doubtless the last course, was better than the first. The plan of lessons drawn up by the Nutrition Division, Department of National Health and Welfare, was used as a basis for the course and a copy was available for each class member. They were encouraged not to think of this only as their property but to make it available and share it with those who worked with them. Subjects dealt with were nutrition, menu planning, modification of menu planning to meet the needs of patients, therapeutic diets, sanitation in food planning, storage of food, purchasing and cost control, work planning and food preparation.

A reference library was set up for class members. It contained quantity recipe books, books on institutional food service, and various interesting pamphlets, available from government departments and food and equipment manufacturing companies.

Different personnel were used in the three institutes, depending upon the resources available in each instance. The Health Branch nutrition consultant and Mrs. B. Jacks, part-time dietary consultant with the B.C.H.I.S., took some classes in every instance. At the second course in Prince George, Pauline Vallières, nutritionist with the group feeding section of the nutrition division of the Department of National Health and Welfare gave valuable assistance. The nursing consultant, the health unit director, health unit sanitarians, local dietitians and a home economist from the Department of Fisheries, all gave their assistance willingly. In the final course, held near Vancouver, it was possible to get assistance from a home economics instructor from the University of British Columbia, and that of a nutrition consultant from the Metropolitan Health Committee.

Food Service

sponsored by the

Canadian Dietetic Association

Practical menu planning was carried out by each class member; advance menu planning was stressed as a guide to ordering and preparing food and planning the work of the kitchen. Each class member had an opportunity to discuss her menus with one of the instructors.

Modification of the general menu was discussed and considerable time was spent on therapeutic diets, including diabetic diets. The use of a reliable therapeutic manual which would be available for the use of kitchen and medical staff and which would lead to a degree of standardization was encouraged.

The sessions on sanitation gave a simple explanation of bacteria, what they are, their danger, how they spread and how they can be controlled. Parts two and three of the film on Hospital Food Service Personnel Training* were invaluable in illustrating good practices in food handling. It was suggested by many of those attending the institutes that such films be made available to all kitchen workers.

Practical food preparation is difficult when time and facilities are limited. Local school boards, however, came to the rescue by granting permission for the use of home economics laboratories. These facilities enabled a home economist from the Department of Fisheries to show up-to-date methods of fish cookery and how they can be applied in an institution. At one institute the preparation of supper dishes was demonstrated; important points in the preparation of vegetables and the use of skim milk powder were included.

The film strip "Beef" was used to emphasize important points in meat preparation. Control of the oven temperature (and use of a meat theremometer) was integrated with the cost factor and the palatability of the finished product.

Classes on purchasing, storage, and cost control emphasized that all steps in food service from the initial menu planning through to the final serving on the patient's plate have an influence on the cost per meal.

Tray service dealt with the importance that is attached to the final presentation of food to the patient. Good planning, skilful preparation, and good organization within the dietary department, are all part of serving the food attractively, hot or cold as the occasion demands, at the patient's bedside.

Participation in discussion periods at the close of each session was enthusiastic and many problems were discussed. Questions covered a wide range, *e.g.* rotating menu plans, time of meals, the advisability of serving dinner at night rather than, as traditionally served, at noon. Several hospitals in British Columbia, as in other provinces, have changed the main meal to the evening, and smaller hospitals are following suit. The need for evening nourishment is lessened and adjustments in staff time tables have been readily accepted.

The contribution of the B.C.H.I.S. nursing consultant was a decided advantage when problems between nursing service and dietary service were discussed. Food is an important part of treatment in patient care and co-operation between the two services is essential. The development of a good working relationship was encouraged.

The enthusiasm of the class members was extremely satisfying. Personal expressions of gratitude and appreciation were almost overwhelming. This was partly due to the fact, which cannot be over-

(concluded on page 93)

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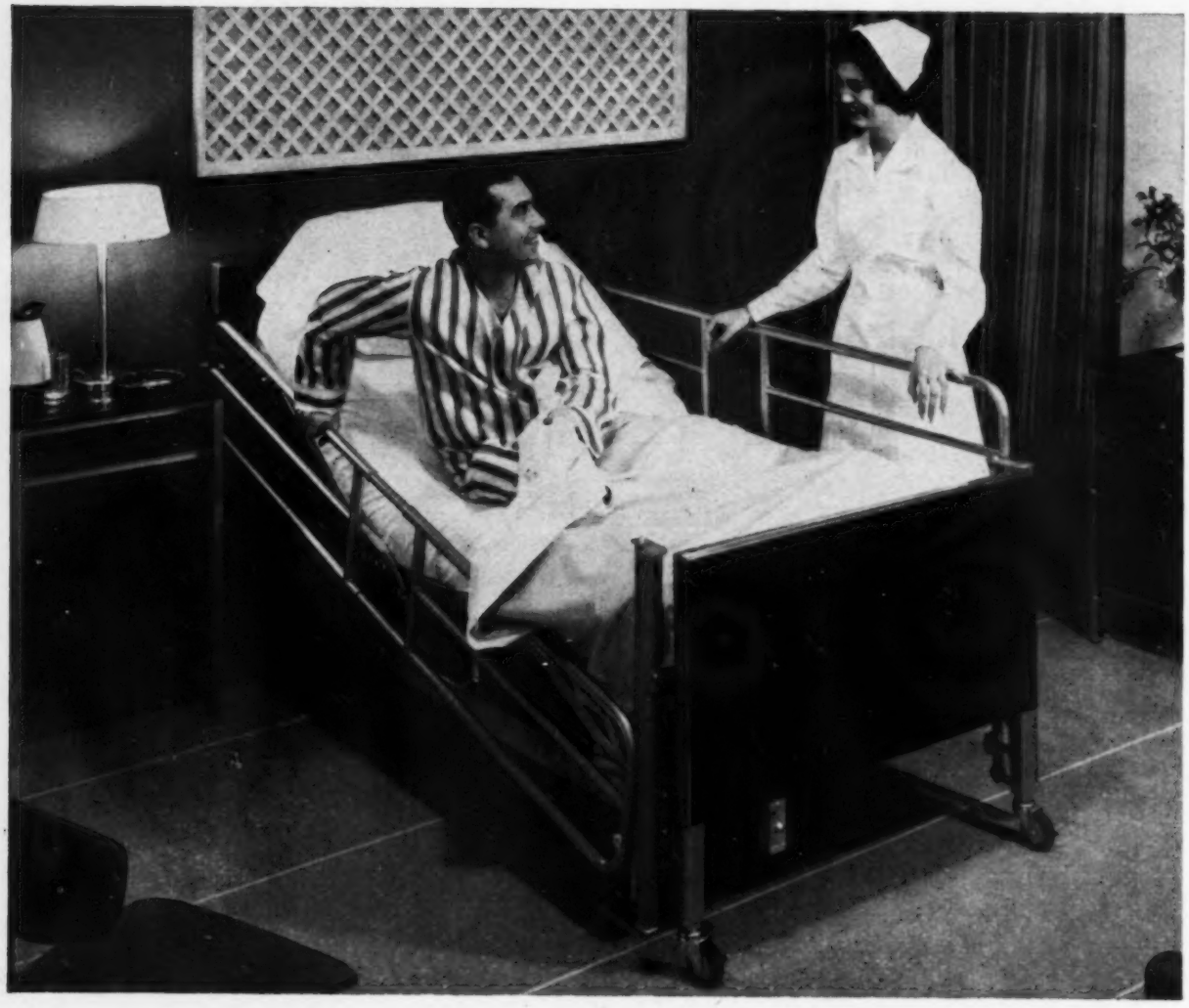

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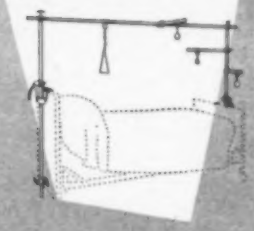

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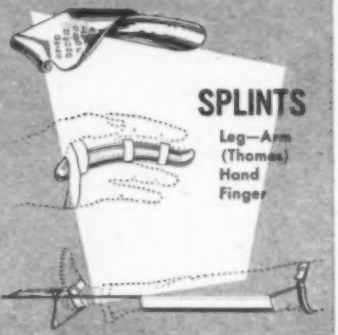

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Leg—Arm (Thomas) Hand Finger

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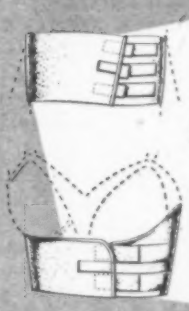

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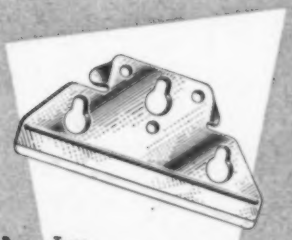

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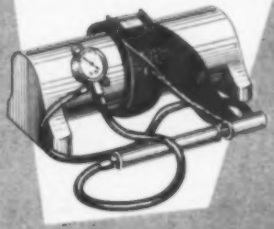

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Trends and Developments
(concluded from page 37)

riculum and its implementation. There is a movement away from a preponderence of didactic teaching and one toward more emphasis on student participation. You will admit the soundness of this movement and see in it the influence of the trend in education generally.

This would seem to be the appropriate context in which to mention the importance of the library in the life of the student. Four schools now employ a full-time registered librarian and five a part-time. Another school has a full-time person who is not a registered librarian. The recent decision of the Ontario Hospital Services Commission to allow a specific library expenditure is an extremely important development. Much improvement is anticipated in this area.

Faculties are directing their attention during the student's introduction to nursing to the development of skill in communication and in identifying, understanding and solving problems in the care of patients. Instructors are seeking ways to plan the experiences which students will have. It is hoped that this trend will be strengthened by the new regulations in regard to nursing services requirements in those areas where students are assigned for experience. In new hospital construction, classrooms are being provided in conjunction with the clinical areas.

The hospital school of nursing offers a three year program. Following an introduction to nursing the student has successive experiences in the clinical field with appropriate instruction. This plan is replacing the so-called "block system." For many years the trend had been to cover most of the theoretical instruction in the first two years with a particularly heavy first year. There is an encouraging swing away from this through the development of more clinical teaching and through the relating of instruction to the care of the individual patient.

Eight schools describe their three-year program as two-plus-one, indicating that the administrators of the school endorse the principle of a service internship in the third year. There are at least four features common to the two-plus-one arrangement. In the third year the student is called a nurse intern; and receives a substantial stipend. In the third year also, the student receives comparatively little planned instruction, with a maximum of practice under a service internship plan; and has an experience in ward administration.

In planning this type of curriculum, each of the eight schools stated as objectives a stimulus to recruitment and more opportunity to arrange planned experiences for the student in the first two years.

There has been no assessment of the degree of achievement of these objectives because there has been no study of all hospital schools in these respects to permit a comparison.

The trend still is to provide residence accommodation for students. There are obvious educational advantages in this for the majority of students if not for all. An examination shows that approximately one-third of the schools have physical facilities which are adequate in all respects. This is not easily explained when it is known that in the past ten years 19 hospitals have constructed new buildings for their schools and 12 others have extended their school buildings. Six months ago, two hospitals had buildings under construction and six were in the planning stage.

Most schools enroll applicants who have the minimum qualifications of secondary school graduation diploma with the required science option.

It is known that many directors of schools of nursing counsel applicants to return to high school for a fifth year. Returns on the educational qualifications of the 2,700 students who entered schools in 1960 were not complete enough to provide a reliable picture.

There is now more flexibility in the policy of some schools in regard to the admission of the married applicant and to the marriage of students during the course.

Administrators and teachers in schools of nursing, alike, are thinking and talking about the status of this learner, the student of nursing. They are trying to relate her preparation to the demands of service which she must meet as a registered nurse. They are trying to do this realistically with economy of time and cost. They want it to be a sound educational experience for the student so that she may learn the knowledge, skills and attitudes which will make it possible for her to go on learning. They see her basic course as the first phase only and look to the employer to extend her education through in-service programs.

In all these trends our association is a positive force in plotting future basic nursing education. Through the stimulus of working committees, educational projects and guidance from provincial office personnel, the association has helped its members to crystallize their ideas.

To summarize, one can say that the task of providing for the education of the registered nurse in sufficient numbers has been carried and still is being carried primarily by the general hospital schools of nursing. It is apparent that existing facilities are inadequate for future enrolments. There is a discernible and self-directed movement on the part of school faculties to establish more controlled teaching situations for the student of nursing. The supply of instructors and nurses prepared to assume the direction of schools is crucial to the future of nursing education in Ontario. ■

Course in Nursing Unit Administration

Nurses interested in enrolling for the extension course in nursing unit administration should submit their applications not later than June 1. Applications will be accepted from nurses who are engaged in positions of assistant head nurses, head nurses or supervisors and are unable to attend a university school of nursing. Directors of nurses in small hospitals may also enrol.

The course will start with a workshop in September to be followed by a seven month period of home study. A final workshop will be held in May of next year.

This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. (See *Canadian Hospital*, November, 1960, p. 33).

Information and application forms may be obtained by writing to: Director, Extension Course in Nursing Unit Administration, 25 Imperial Street, Toronto 7, Ont.

Components of Cost
(concluded from page 40)

How many years are needed to educate a nurse to meet today's demands for nursing care? Do today's demands differ significantly from those of years ago and, if so, are different objectives, curricula and length of program indicated? What does nursing education cost?

Answers to these questions were provided by the Lord Report of the experimental program at the demonstration school in Windsor, Ont., during the years 1948-1952. This report showed conclusively that, if the school is given full control of the student's time, a nurse can be as well prepared in two years as in three.

Ten years later the question, *what will it cost?*, recurs persistently when discussions on experiments and changes in nursing education arise.

Let us examine some of the items which often appear as educational expenses and which give rise to expressions of concern on the part of hospital authorities, the nursing profession and the Commission. (See Form 1). For instance, the inclusion of expenditures of public funds for graduation expenses is seriously questioned as being a legitimate charge against nursing education.

It was obvious that such wide variations were creating problems particularly in localities with two or more schools. In reducing inequities among the 46 schools of the traditional type and creating a degree of uniformity among the eight schools conducting "2 plus 1" year programs, the Commission recognized that inequities between the traditional three year and the "2 plus 1" year programs remain unsolved.

The Commission supports the thinking of the organized profession and the Council of Nursing* that schools of nursing should be established as educational entities with separate budgets, that students should not be subsidized by such emoluments as stipends, text books and uniforms, but that other forms of assistance such as bursaries should be made available.

The Commission was aware that, by requiring an annual statement of income and expenditures on behalf of its school of nursing, certain problems would arise, because generally speaking, it has not been current practice to separate the income and expenses of a school of nursing from those of the hospital. However, the Commission's budget form No. 10 has provided the basic information to answer the question—what does nursing education cost? Improvements in form No. 10 will be made in the future and should result in more accurate data. (See Form No. 2 which gives the type of data obtained by budget form No. 10.)

Finding true costs is complicated by the difficulty in determining the value of student nurse services. Studies on this aspect have usually been based on the service value of the student in terms of the graduate staff nurse. The percentages used varied from 25 to 50 for the first year student, 55 to 75 for the second year student, and 75 to 87.5 for the third year student.

There is no question but that nursing service rendered by students has a certain value, but whether that service value should be expressed in terms of the professional nurse or in terms of the activities the student nurse is undertaking is another matter. It was in this area that the variations in methods of reporting led us to doubt its validity. In some instances very few hours were credited to student services, in others more were recorded than could possibly have been given.

The establishment of a separate budget for nursing education will provide proof as to whether or not the student is being exploited through service, or whether the hospital is being exploited by its school of nursing. It will provoke the realization that many of our policies need to be revised in the light of today's costs so as to become consistent with today's educational practices.

It will emphasize the need for clearer understanding of the components of cost so that charges may relate to incurred costs, as is the case in other educational institutions, *e.g.*, tuition should be a charge for instruction. By definition this means "the price of or payment for instruction."

Maintenance is an item that needs great consideration since it is in this area that hospital schools depart most radically from the practice of other educational institutions. According to data furnished by form No. 10, a single room may cost as little as $5 per week or as much as $10 per week, while meal charges range from 50 cents to $1.15 per day.

By establishing a more businesslike and realistic method of determining costs for room and board and giving credit for clinical services rendered by students, hospitals will conform more to the pattern set by other educational institutions.

The introduction of sound accounting and record keeping procedures will provide factual information on which justifiable charges and credits can be based. The school of nursing must accumulate data on hours spent by students in clinical practice and, in co-operation with the nursing staff and the administrative officers of the hospital, determine *replacement* values for this time.

The very process of analyzing costs brings light to fundamental problems of nurse education. The findings will make possible informed, thus wiser, answers to such questions as:

- should tuition fees be increased so as to cover educational costs more closely?
- should the value of student service be credited against charges made for room and board?

In conclusion, the O.H.S.C. endorses the statement of the Canadian Nurses' Association:

"If nursing service is to meet the needs of new health programs and is to keep pace with advancements in medical science, programs in nursing education will require compensatory changes. Since the maintenance and improvement of nursing services are contingent upon the quality of educational programs, continual experimentation would seem indicated to prepare nurses: (a) as quickly as possible, consistent with sound educational principles; (b) as economically as possible to the student and community; (c) as thoroughly as possible to insure quality of patient care."

The door is open for research and experimentation in nursing education so that authorities responsible for the conduct of hospital schools of nursing may keep faith with the student and the public.■

An advisory council to the Minister of Health for the Province of Ontario.

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*Carl W. Walter, M.D., "Aseptic Treatment of Wounds" (New York: The Macmillan Company, 1954), P. 172

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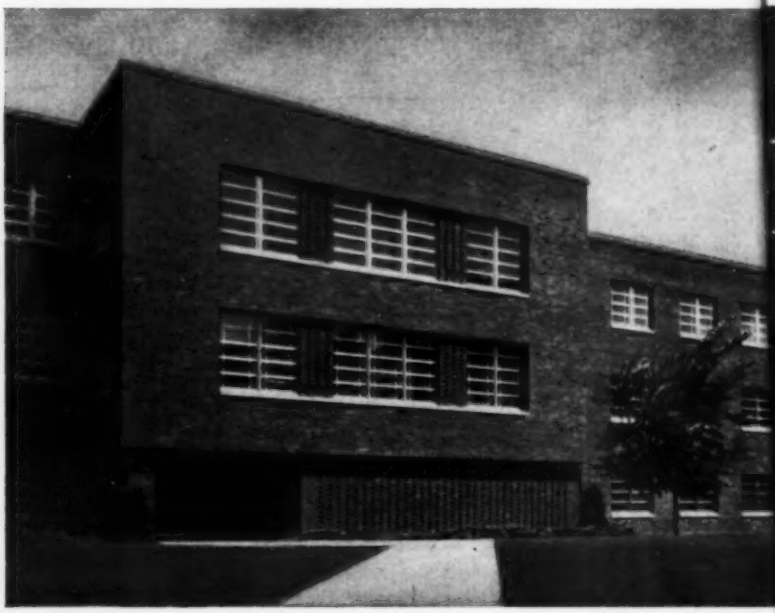

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CONSULTING ENGINEERS:
Scott & Kinney, Kansas City, Missouri

MECHANICAL CONTRACTOR:
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Final check on the U. of K. Psychiatry Building's pneumatic control system by the consulting engineers, Wilson O. Kinney (left) and Arthur R. Scott.

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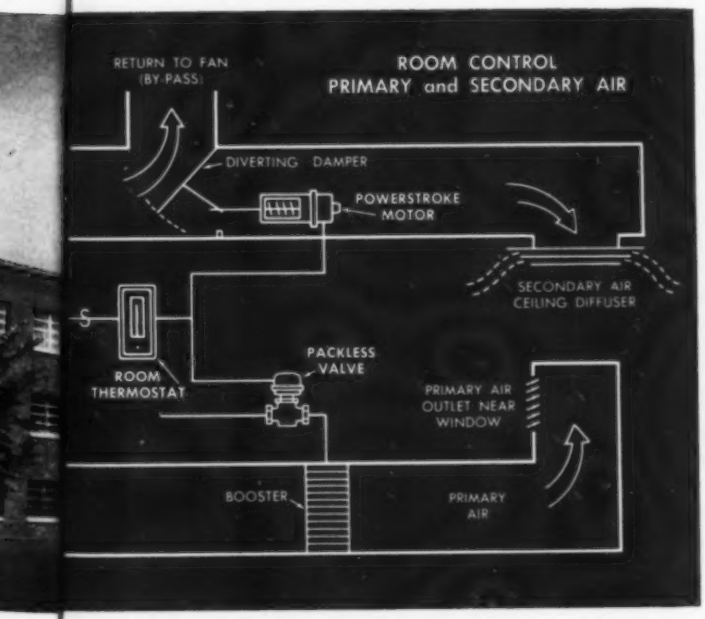

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College of Nurses

(concluded from page 43)

to the Minister in 1959—although at that time the request was on behalf of the Registered Nurses' Association of Ontario.

Following the Minister's suggestion, many days of committee, executive, and general meetings were held by the Registered Nurses' Association of Ontario to study the proposed College of Nurses. As with any new concept, it was necessary to find principles on which to build and against which ideas for implementation might be tested. A study in the Parliamentary library brought forth what has happened in relation to other professions in this province. While there was no distinct pattern in relation to all the professions, the study confirmed the fact that while the majority of the professions had a separate statutory body for the control of minimum standards of education and practices, all such bodies were composed solely of members of the profession concerned, except for the appropriate Cabinet Minister as the elected representative of the people. The Registered Nurses' Association of Ontario, at its annual meeting in 1960, instructed its board of directors to seek nursing legislation, based on the concept of a Colleges of Nurses. The basis would conform to the definitions of a profession long accepted by society, such as that enunciated in 1915 by Dr. Abraham Flexner for the medical profession and that of Mary Parker Follett who stated: "The word 'profession' connotes for most people a foundation of science and a motive of service." That is, a profession is said to rest on the basis of a proved body of knowledge, and such knowledge is supposed to be used in the service of others rather than one's own purpose.

As Miss Ella Howard, president of the Registered Nurses' Association of Ontario said, at a recent special meeting of the membership of the R. N. A. O., "The Minister of Health has, over the intervening months, been most generous in granting us interviews. He has been most understanding, supportive and helpful as we have all tried to think through the many problems relevant to securing the best type of nursing legislation for the profession and for the protection of the public whom we serve."

As chairman of the Working Party appointed by the executive committee of the Registered Nurses' Association of Ontario, it has been gratifying to me to note an acceptance of the fact that the nursing profession is seeking the answers to the question, "What is best for the public we serve?" This has been demonstrated by those bodies immediately concerned, having agreed with the principles, on which a draft act to establish a College of Nurses would be based. The principles are:

1. A profession has the right to determine its own standards of education and practices.

2. The control of minimum standards through a governing body composed of: (a) representatives elected by every member of the profession resident in Ontario—these to comprise the majority; (b) representatives from the organized profession; and (c) the appropriate Cabinet Minister.

Several policies have also been agreed upon to assure the relationship of the R.N.A.O. with its national and international counterpart and to indicate the necessity of liaison with other groups for advisory purpose and/or interpretation of areas of common interest.

At the request of the Minister, the association has prepared a draft Act. This is in his hands for consideration. The proposal outlines a governing body with the suggested name of "Council" to administer the affairs of the College, according to the principles quoted above. The Minister of Health would be a member of the Council ex-officio, with full voting powers. He would represent and protect the interests of the people of Ontario who are vitally concerned. They are the consumers of nursing and ultimately pay for all service rendered. They are concerned in the kind of nursing they receive and with the preparation of the persons who render them the service they pay for.

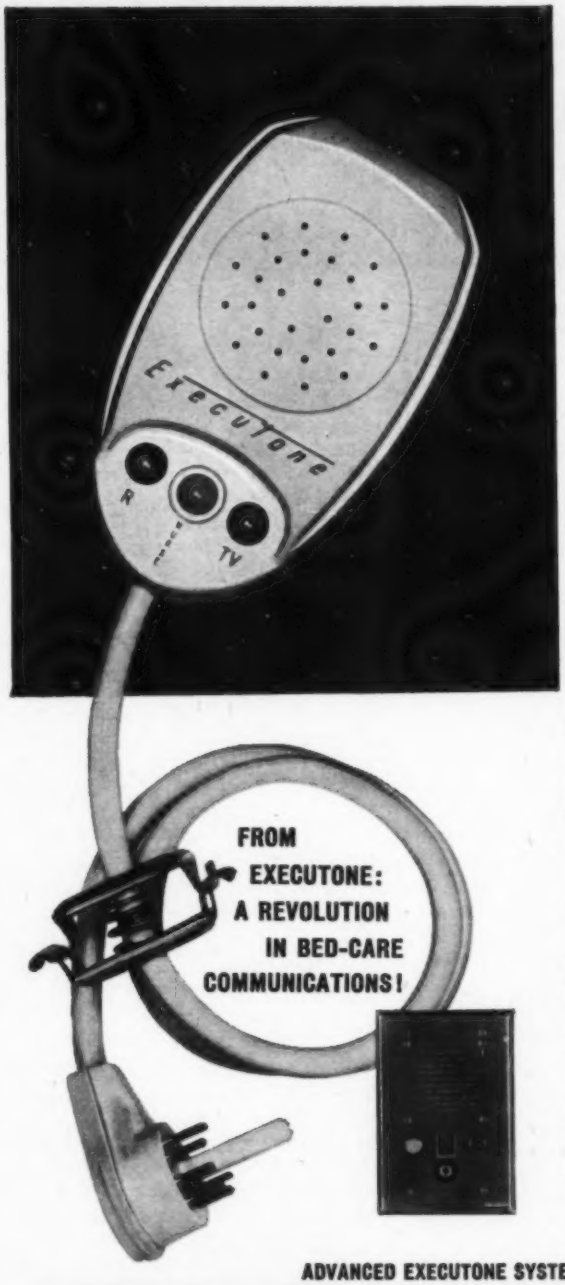
Further, it is proposed that there would be a group of registered nurses on the Council elected from and by all registered nurses in the province, in sufficient numbers to ensure that they would have the voting majority. The remaining group would be appointed representatives from the organized profession. They would be the liaison between the organized profession and the College and be the means of bringing to the Council the official recommendations of the Association at all levels — international, national and provincial.

The proposal has been made that in addition to present statutory powers now in effect in the two Acts of 1951, further consideration be given to licensing of nursing personnel. The proposal also suggests limiting the use of the words "nurse" and "nursing" to persons licensed under the Act. One result of such limitation would be that the public would know, if they employ *nurses* to give *nursing* care, that those rendering that service would be adequately prepared to do so. The association has stressed that if and when such legislation is obtained, a period of some years would be required before implementing this clause in order that there be ample opportunity to assist those at present nursing without legal status, to qualify for licensing.

The concept of a College of Nurses has created lively interest in many directions. When will an Act be introduced to the legislature? This is dependent on many factors inherent in the consideration of new legislation. The nurses await developments with interest. No matter what happens this year or next year, there is much to be done by all concerned. A study of present regulations under the two 1951 Acts, in order to see what can be done now under present legislation, would be useful and the R.N.A.O. has started this. Recommendations for change will be useful, should the new Act become a reality. In addition, nurses and employers of nursing personnel can do much to clarify the status of those who have formal preparation for nursing, over 33,000, and those who are giving some type of nursing care, with limited or no preparation, numbering some 30,000. We can improve nursing education, control nursing practice and tidy our houses so that if the day arrives when the College of Nurses becomes a reality the changeover may be accomplished smoothly, to the satisfaction of all concerned. ■

Meeting for Clinical Chemistry Society

The fifth annual general meeting of the Canadian Society for Clinical Chemistry will be held June 2 to 3 at the Ontario Veterinary College, Guelph, Ontario. All those interested in clinical chemistry are cordially invited to attend and participate. Those interested in becoming members of the Society, please write to Dr. D. B. Tonks, Secretary, The Hospital for Sick Children, Toronto 2, Ontario.



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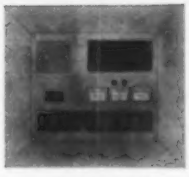

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COMMUNICATION and SOUND SYSTEMS

Economic Aspects

(concluded from page 52)

shares community responsibility for social health, surely we cannot fail to be concerned with the welfare of members of our own profession. Then, too, I think we have evidence that poor social adjustment leads to poor nursing. So we have to spend time in at least directing a service to find adequate accommodation. We must also do something to combat loneliness through our staff associations or by other means.

There is one more significant aspect to this situation. Although the travelling staff are competent and willing to work for their salary, I wonder how much the hospital loses financially because so many of its staff tend to see it as a means toward travel and new experience. They lack the sense of personal identification with the hospital possessed by the old retainer who would gladly give so much extra in loyalty and generosity of service. The nurse who has this identification will see that economies are practised in supplies and service just because she feels a part of the institution. I would like to emphasize that I do not imply criticism of the staff who come for a short stay; rather I would like to pay a sincere tribute to their adaptability and sense of responsibility toward the institution. I am referring to another attitude, i.e. the sense of personal identification, which I think can only grow in time.

Using the Nurses' Time

It is frequently contended that, in Canada and elsewhere, there is not so much a shortage of nurses as there is a shortage of nursing. It is a prevalent opinion that nursing is costing hospitals more money than necessary because nurses are frequently prevented from doing the work they are prepared to do with a minimum expenditure of time. Much of the responsibility for this situation must be borne by the nurses; and the profession is aware of the need for more research to streamline nursing procedures and ward management. There are many problems here which lie beyond the power of the nurses to remedy. They need the help of hospital administrators, doctors and an informed and interested public.

I imagine that most of us would agree that nursing is one of the most expensive services of the hospital and one of the most fundamental to success in achieving the hospital's goal. Perhaps then it is economically sound that there be joint planning to bring about its best use. For example, the question of the assignment of patients to nursing units has been critically examined in many places by many people. Is the old division according to private, semi-private and public accommodation or according to medical and surgical grouping still sound, or would assignment according to the kind of medical and nursing care required give better service and economize on nursing? Should we think in terms of assigning patients who require intensive care to the same area where a larger staff of qualified nurses and the necessary equipment could be concentrated? Patients who require longer but less intensive care need another kind of nursing, and those about to go home still another.

I believe, too, that closer communication between nurses and doctors on wards would make it possible for us to give the doctors better service in caring for their patients. Perhaps as nurses we have neglected to explain our problems to doctors. We often feel that doctors could reduce the frequency of some medications, treatments and routines, or develop more uniform orders, if they knew the time spent in the present situation—time which could be spent teaching patients about health and creating a human environment which promotes health and healing.

As nurses we have been remiss in not bringing some of these problems to the attention of doctors and administrators. We as nurses feel we could save the hospital time and money if we were brought in early in the planning of new programs of service, research or building.

Changes in Medical Practice

Although changes in the treatment of some diseases (such as pneumonia) have lightened nursing, it is found by experience that all the changes add up to an increase in nursing time. The changes brought about by the use of new drugs, the advances in heart and chest surgery and in neurosurgery, the new equipment and the great increase in medical research have all meant time-consuming duties for the nurse. The tremendous increase in the use of drugs takes much more nursing time; on medical floors the full time of one nurse is absorbed in the giving of medications. Even early ambulation in most cases adds to nursing time rather than decreases it. It was much easier and much faster to care for helpless patients in bed than to help them into gown and slippers, prop them in a chair and undress them for bed again, not to mention the time spent in persuading the unwilling that it is good to get up.

Other Reasons

Nursing in the province of Quebec could give more economical service if there were a larger supply of nursing assistants; but we have not been able to find the resources to finance their education. We need the help of the public, too, for we must find ways to use the nursing resources which could be tapped in the families of many patients if nursing care and some of the other hospital services were extended to their homes.

One thing I have not said, which should be obvious, is that *much* nursing is required. Often this is forgotten when one tries to understand why nursing is so expensive in comparison with some other services. It cannot be closed down at 5 o'clock or on Saturdays and Sundays. As it was so ably pointed out by Dorothy Wheeler*, the 40-hour week for nursing really amounts to 168 hours. ■

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* Wheeler, Dorothy V., "What Medicine Has Done to Nursing". The Modern Hospital, February, 1954.

Calling all Technicians

The Third International Convention of X-ray Technicians, sponsored jointly by the American Society of X-ray Technicians and the Canadian Society of Radiological Technicians, will be held in the Queen Elizabeth Hotel, Montreal, P.Q., June 24 to 29, 1961. The joint committees under the general chairmanship of G. Archie Wilkinson, supervisor of the department of radiology of Montreal's Royal Victoria Hospital, has prepared a program of lectures, luncheons and entertainment which should attract and hold the interest of everyone throughout the entire convention.

Refresher courses will be held daily. Distinguished speakers will address the scientific sessions and two memorial lectures will be given —the Jerman Memorial Lecture, presented by the A.S.X.T., and the Welch Memorial Lecture arranged by the C.S.R.T.

A varied program of social events will mark the lighter side.

Twenty Years Ago

From Canadian Hospital
April, 1941

Unappreciated Luxury

It seems odd that Germany should be protesting the use of old Fort Henry at Kingston as a camp for German prisoners. Not many people actually have visited this historic old spot at Kingston which is probably as costly an abode for prisoners as is used on either side in this war. Last year in the Ontario legislature, in an answer to a question, it was stated that the cost of restoring and renovating this old fort amounted to $831,895. This summer, when most of us will be sizzling in temperatures in the 90's, this prison will probably be about the most comfortable place in Eastern Canada.

Kingston General Issues Bulletin

Kingston General Hospital has just issued its first Information Bulletin which is to be a monthly feature. The bulletin, a mimeographed sheet, will go to the governors, the Women's Aid and donation subscribers. It tells how the donation fund has been spent and carries news items as well.

Naming of New Fort Frances Hospital Honours Historical Figure

The new hospital to be operated by the Sisters of Charity at Fort Frances, Ontario, will be known as LaVerendrye Hospital in honour of the man who established the first white man's camp within the boundaries of that town.

Pasteurizing Effective

The Department of Health for Ontario has reported that as a result of recent legislation 98 per cent of all milk sold for fluid consumption is now being pasteurized and that there has been a marked reduction in diseases which may be milk borne. Typhoid fever has been reduced 50 per cent and undulant fever 45 per cent. At the time of introduction this legislation was strongly opposed by certain individuals, but this protest, which has been steadily decreasing will have more difficulty now in overcoming definite factual evidence of the efficacy of pasteurization.

Home Care and After Care in Australia

The Royal Newcastle Hospital in New South Wales, Australia, commenced its domiciliary care scheme late in 1954. It is under the control of the staff physician, with the co-operation of the patient's family doctor, who provides day-to-day medical care. The staff consists of two district sisters and two nurses in training. One team provides a nursing service for six days a week in the inner area, the other attends three times a week in the outer area. Housekeepers are supplied by the Department of Child and Social Welfare but are paid by the hospital. Physiotherapists are responsible for the patient's appliances and exercises.

The Domiciliary Care Committee meeting weekly, decides what services are required by each patient, most of whom are pensioners. After a year's experience two 35-bed wards were taken over as a geriatric unit. Patients are admitted from the main hospital or from the domiciliary care scheme for training in the art of daily living. It has been possible to reduce domiciliary care for patients rehabilitated in the geriatric unit and thus the domiciliary care staff are able to help more patients.

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Nightingale School
(continued from page 42)

meeting went on record as approving a pattern of basic nursing education. While several recommendations were made, the more significant are as follows:

1. The basic professional education for nursing be a two-year program which qualifies the candidate for a diploma and registration, and which meets the following criteria:

A school has its own governing body, advisory committee; budget; well prepared staff in adequate numbers; control of the student's time; and essential physical facilities.

2. The educational requirement for admission to the two-year program be the secondary school honour graduation diploma.

3. Diploma program be set up under the following authorities: universities; colleges affiliated with universities; hospitals; and independent regional schools.

4. Steps be taken to establish two-year programs in selected institutions.

5. Public financial support be sought to implement the programs.

Further recommendations dealt with the practical aspects of preparing persons to develop such programs, by institutes, conferences, revision in legislation, the use of a curriculum guide and by joint consultation with the Registered Nurses' Association of Ontario and Nursing Branch representatives.

The Association is convinced that a two-year program which is educationally sound would: (a) attract more candidates and thus alleviate the shortage of nursing; (b) result in a better prepared professional nurse; (c) result in a young graduate nurse wishing to remain in the hospital where clinical experience was obtained, thus stabilizing nursing service; and (d) result in better care.

A central school of nursing is interpreted by the Association as one which would meet the criteria as outlined for a school conducting a two-year program but would use the facilities of several hospitals and service institutions for the clinical experience of its students. Such a school could be an entirely new entity in an area where no schools currently exist, or it might be an amalgamation of two or more existing schools in a regional area which would be willing to give up their identity.

The Association believes that a central school of nursing would: (a) relieve institutions providing the clinical experience of the cost of conducting a school; (b) relieve the shortage of prepared personnel by a better use of existing personnel; (c) improve the quality of instruction; (d) result in better planning and use of physical facilities; (e) would provide for better distribution of nursing personnel throughout the province; and (f) stabilize the teaching staff.

In an attempt to prepare for the implementation of these recommendations, interpretation has been given at the annual meetings of the Association, at a meeting of directors of nursing of hospitals with schools, and it was hoped that conferences, such as this one, would be arranged jointly, when interpretation could be made to hospital administrators, chairmen of boards, directors and teaching staff.

Within the Association, extensive study has been given to the preparation of a curriculum guide to assist schools in evolving a program according to the foregoing criteria. Too, the necessary legislative controls have been given consideration.

Inherent in the development of a two-year program is the belief that a new approach in the pattern of nursing education is possible. A two-year program is not an abbreviated, diluted, amputated, or condensed version of the traditional three-year program. It entails the belief that the nurses' rôle embraces, not only therapy, but health preservation, health promotion and rehabilitation as well. It also means that the program is designed to provide the experiences needed by the nurse to prepare her for this rôle; experiences in the clinical field, which are essential in the nurse's preparation, will provide some service value, but the student should not be counted upon to provide the nursing needs of the hospital's patients.

The transition to a two-year program in basic nursing education by an existing school or the development of a new school should be accompanied by intensive interpretation to *all* concerned. In such interpretation members of the community in which the school exists should be included. The teaching staff in particular should be prepared, share a common belief in the program and be aware of their responsibilities in developing a curriculum with objectives which are realistic and possible of fulfillment.

The Association's report and recommendations regarding patterns of basic nursing education programs were presented to and received in principle by the Council of Nursing which is advisory to the Minister of Health. ■

The Nightingale School

Mrs. Blanche Duncanson

THE APPLICATION of the basic pattern of nursing education as recommended by the Association is being carried out in the Nightingale School of Nursing. This is not a trial project, but the re-application of principles inherent in the first Nightingale School of Nursing in 1860 and again demonstrated in the Metropolitan School in Windsor, 1948-1952.

The story of the genesis of the school is of interest. Representation was made by the authorities of the New Mount Sinai Hospital to the Ontario Hospital Services Commission as the financing authority, to consider a proposal whereby an independent regional school could be established on land donated by the hospital, which would observe the recommendations and criteria of a two-year program of basic nursing education as outlined by the Registered Nurses' Association of Ontario. Deliberations took place between the foregoing authorities, and with the nursing branch of the Department of Health, and the R.N.A.O. The federal and provincial authorities were informed of the proposal and assurance was obtained that there would be financial sharing by these levels of government in the cost of constructing, equipping and operating the school.

The official announcement that such a school would come into existence, was made in October, 1959. In the period from October, 1959, to September, 1960, administrative policies were evolved. It was necessary to recruit students and staff in this period and to plan for school requirements, *i.e.*, building and equipment, on both a permanent and temporary basis.

The school at present occupies premises on Elizabeth Street in Toronto, but the permanent building will be at the corner of Murray and Elm Streets in the down-town area.

It is anticipated that the building will be owned by the provincial government, Department of Public Works. The school is sponsored by the Ontario Hospital Services Commission and is administered by a board appointed by the Commission. An advisory committee appointed by the board has the responsibility for advising both the board and staff on educational policy.

The staff members, with the exception of the director, were appointed in July of 1960. Their responsibility is the development and implementation of a curriculum, the objectives of which are in harmony with nursing standards and which are approved by the board, as well as the provincial authorities, who implement the regulations of the Nurses' Registration Act and the Nursing Act.

The first class of students was admitted in September, 1960, and they are receiving a program designed to prepare them as nurses who will be able to plan, coordinate and give the care of persons, healthy or ill, in the hospital and community. The staff of the Nightingale School of Nursing believe that the program will not produce nurses who are capable of head nurse or supervisory rôles without additional study, but that it will prepare nurses with leadership ability within the staff team.

The staff believe that the nurse who graduates from the school will be one who recognizes, understands, and meets the educative, therapeutic and rehabilitative needs of persons, sick or well, by assisting them and their families. One may ask why the emphasis is on health and not on disease. Although the majority of nurses are employed in the hospital field where persons are ill, the nurse must understand the person as a healthy individual and as a member of society, in order to appreciate her rôle in restoring him to health, not only to the point of discharge from the hospital but in restoring him to his usual place in society. So, while the curriculum may be only two years in length, it does represent an expansion of the health concept to include protection from hazards, prevention of disease, promotion and restoration of health, and re-

habilitation. Theory is presented in large units, rather than by separate subjects; principles are emphasized, and learning experiences are integrated throughout.

The school has received several requests for copies of the curriculum. It is not possible to fulfill these, since the curriculum is still in the developing stage. Also, the curriculum, as a conglomeration of words, diagrams and patterns, has little meaning without the concomitance of a shared belief in the purpose of the school, an awareness of the curriculum objectives, and an understanding of the methods of financing the program and the administrative organization. For these reasons, the staff believe detailed interpretation should be made at the local level of the school, and we are prepared to consider such requests.

The New Mount Sinai Hospital has not had a school, but does believe that any or all of its clinical services should be made available to the school. Accordingly arrangements have been made whereby the students receive the majority of their clinical experience at the New Mount Sinai Hospital. In addition, each student has experience with a variety of community health and social agencies. At the present time, negotiations are being carried out with other institutions to secure clinical experiences in those areas which are not available at the New Mount Sinai Hospital.

The students have had clinical experiences since the first week they were in the school, thus attesting to the fact that the school believes in the essentiality of such experience in the students' program.

The budget is prepared by the school, approved by the school board, and submitted on a separate form, along with the budget of the New Mount Sinai Hospital, to the Commission. The school receives its finances via the per diem rate, which is paid to the New Mount Sinai Hospital. The portion of the per diem rate which is applicable to the cost of operating the school is deposited in the school's bank account. The school is responsible for ordering its supplies directly from the supplier as well as paying its accounts. The New Mount Sinai Hospital has undertaken to provide dietary, laboratory, laundry, and certain administrative services for the school, for which the school pays the costs, direct and indirect.

While the school has only been in operation since September 29, 1960, I can unreservedly report that the staff are finding their experience challenging, provocative and satisfying. We realize that the value and confirmation of our beliefs will be reflected in the quality of the product we are preparing. We are keenly aware of our responsibilities, not only for the students who have entrusted themselves to us, but also for the influence of the school on nursing education in this province. ■

When to Motivate?
(concluded from page 47)

learn to delay her personal satisfactions.

We must be cautious in our selection of graduates for such individual attention. Their guided experiences as team leader or assistant head nurse will be helpful factors in determining whether or not they have the stability, consistency, courage and human understanding, necessary for successful supervisory performance. All these must be considered in their evaluation before they may consider themselves prepared, through study, observation and experience for university administrative work.

A recent survey in our nursing service department shows that the majority of nursing service supervisors believe that motivation should begin in the first year of nursing. This is very revealing, since it illustrates the basic desire or need to see good nursing in practice. Inspiration must come from the ward situation, not from the classroom. Enthusiasm on the part of supervisors will urge general duty and student nurses to excel in providing optimum patient care. In order to stimulate interest in nursing service administration, we must have interested supervisors.

In summary may I reply to the question by saying that planned direct group and individual motivation should begin in the senior year, provided this has been preceded by indirect group motivation from the first year of nursing, and is supplemented by immediate individual motivation for the graduate nurse. ■

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How to Motivate?

(concluded from page 46)

possession of this knowledge are better equipped for leadership in nursing. Are good suggestions which are made in discussion groups or conference acted upon promptly? Unless some of these can be incorporated into our practices, the value of conferences is doubtful.

Personnel Policies and Practices

Personnel practices and salary should be considered as motivating factors. Economic security is important, and moreover, it is only business-like to receive adequate remuneration for any classification and increased salary for additional responsibility. However, if we consider leadership to be confined not exclusively to promotion, but within the terms as stated earlier, then this does not apply. Salary is not of prime importance to the professional nurse but her income should be adequate to allow her to maintain a standard of living expected of a professional person, and commensurate with salaries of other professional persons.

I hope that the foregoing suggestions will help us to motivate nurses so that each may be made to count as a person and as an effective part of her group and of society as a whole.

References

1. Follett, Mary Parker: *Dynamic Administration.* Harper and Brothers, 1940.
2. Follett, Mary Parker: *The New State.* Longmans, Green, 1920.
3. Peart, Douglas R.: *Problem Area: Nursing.* Hospital Administration and Construction, Sept. 1960. ■

School for Nursing Assistants

The fifth school in Nova Scotia for the training of auxiliary nursing personnel has been opened in Halifax. The school, to be known as the Halifax Infirmary School for Nursing Assistants, will be conducted by the Sisters of Charity at the Infirmary. The course includes ten months of instruction in the theory and practice of nursing.

The school has been approved by the Board of Registration of Nursing Assistants of Nova Scotia and its graduates will be eligible to write examinations prescribed by the board.

New Wing to Royal Jubilee

Demolition work has been started on the old administration building of the Royal Jubilee Hospital in Victoria, B.C. to make way for the construction of a new five storey wing. The new addition will include a complete surgical floor, a cancer treatment unit, a radiological suite for diagnostic services, and administrative areas.

Tuberculosis Centre in Portugal

The Santa Casa de Misericordia in Lisbon is to collaborate with the National Welfare Institute for Tuberculosis in setting up a rehabilitation centre for tuberculosis. It will consist of a rehabilitation unit of the hospital type and a residential colony which will contain workshops, farm buildings, a church, and a recreational and cultural centre. The unit will be able to deal with 592 patients; it is intended for patients already clinically cured or whose treatment is nearing completion. Here they will either be taught to re-adapt themselves to their former work or, if this is not possible, be trained for a new trade or profession.

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Here and There

Centre for Education in Hospital Administration

An advanced centre for education in hospital administration will be established by the University of Minnesota in Minneapolis through a four year grant of $159,000 from the W. K. Kellogg Foundation.

Since the mid-1940's, this foundation has aided a number of universities, including the University of Minnesota, to develop graduate programs in hospital administration, with special emphasis on the preparation of hospital administrators. There are now 14 such centres in the United States, two in Canada, three in Latin America and one in Australia. The advanced centres go beyond purely preparational level. In addition they sponsor basic and applied research, varied continuing education programs, community service projects, and the formal preparation of research and teaching personnel.

Continuing education is a rapidly expanding means of further education for practising hospital administrators. It is concerned not only with the continued development of recent graduates of university programs in this field, but also with on-the-job training for the several thousand hospital administrators who have never had formal education for their duties in the complex hospital sphere. Consequently, the advanced centres are expected to develop programs to supplement the in-service educational offerings of the American Hospital Association and the American College of Hospital Administrators.

Through the grant just announced, the University of Minnesota will develop doctoral programs in education for hospital administration which should considerably improve the preparation of research and teaching personnel in the field of hospital administration.

New Hospital for Agadir

The regional medical centre at Agadir, Morocco, was completely destroyed in the fatal 12-second earth tremor in February of last year. The building stood for a quarter of an hour after the initial shock; five minutes before it collapsed, medical and nursing staff had evacuated all 300 patients.

The Red Cross is planning a new 400-bed hospital and medical centre to be built in the city and the chairman of the League of Red Cross Societies has invited national Red Cross Societies holding unexpended relief funds for Agadir to contribute these towards the hospital.

The institution will have a laboratory and dispensary facilities, a nursing school and living quarters for professional staff. It will consist of a series of pavilions, each with a capacity of 35-50 beds and only one story high, following a decision by engineers from various countries that no multiple-storey building should be erected.

Funds totalling approximately $500,000 have already been contributed by national Red Cross and allied societies. Costs in addition to those covered by contributions will be met by the Moroccan Government.

A memorial cairn to Sir William Osler has been erected by the Medical Historical Club of Toronto at Bond Head. This memorial has been placed at the site of the rectory where he was born in 1849.

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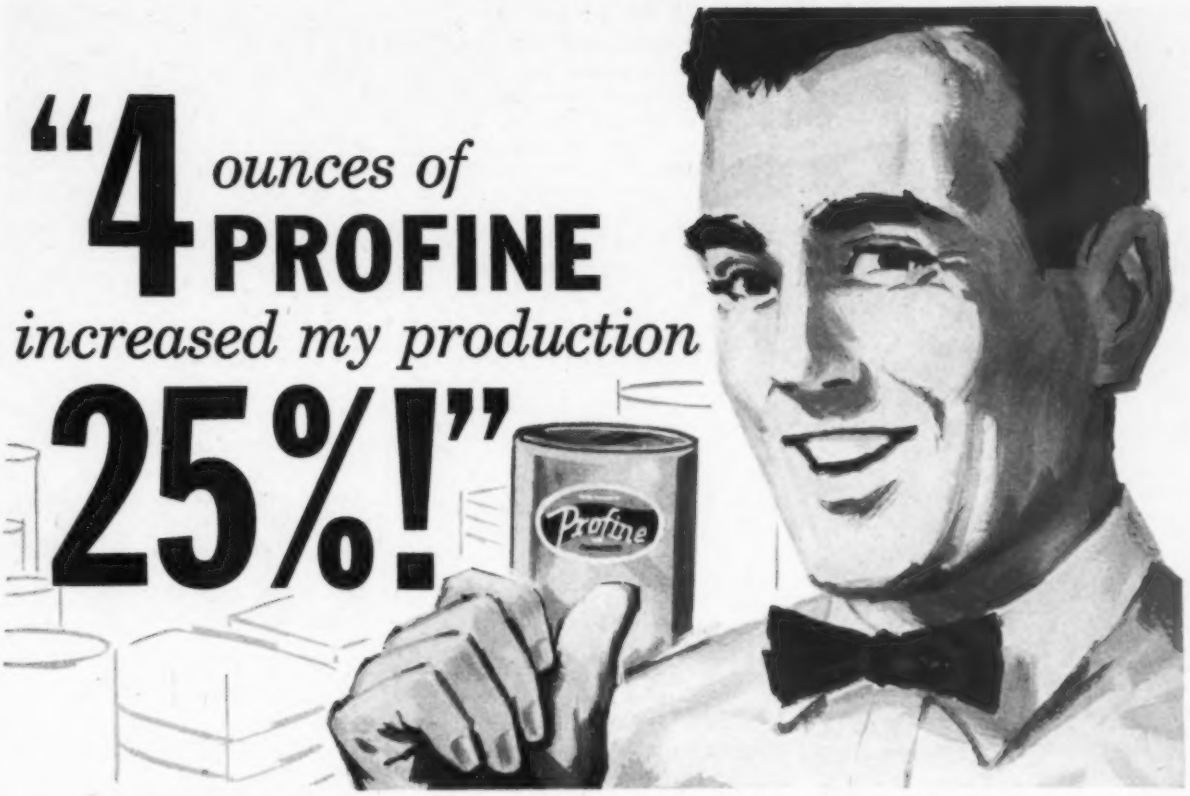

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A Hospital Library

(concluded from page 51)

and other requirements. It is true that decent working conditions are desirable for any type of service, but, in an active treatment hospital, the library service is taken to the bedside and reading areas are not required to any extent within the central library facilities. Consequently, space for the library can be limited to the bare necessities of work space and storage; and of more significance than reading area is the importance of setting the library up close to the receiving department of the hospital where books and magazines can be brought in with the minimum of delay and physical effort for sorting, cataloguing and storage. Steel shelving is used in the library at the Ottawa Civic Hospital and the Dewey classification system is also used. The turnover of books is very important which means keeping up to date with volumes which may be considered as old favourites, as well as the new. It is also necessary to have books which appeal to both young and older patients and to people with language problems. Those with physical disabilities may need special assistance. All of these features can be developed with experience and by paying attention to requests. In this respect, books in different languages are now offered to new Canadians while they are patients in the Ottawa Civic Hospital. Some books are available in Braille and a recent innovation has been the provision of playing cards for veteran patients. More recently, spectacles with recumbent lens have been donated to the hospital by the Library Committee for patients who have difficulty in sitting up.

In our experience, the library service for patients is not only a good thing, but a very important activity. Most patients need some form of diversional therapy which is provided by the library. But, above all, too many people forego the pleasure of reading in our busy way of life; and an opportunity to read while laid up in hospital is one of the most satisfying experiences which can be provided for many patients. Regrettably, many people lack a sound knowledge of English literature. What could be more enriching than to have the oportunity and privilege of reading good books and becoming better acquainted with our own language and the philosophies of famous writers? ■

Administrative Techniques

(continued from page 49)

could notify the housekeeping department well in advance of the patient's departure, the patient's unused drugs could be returned to the pharmacy in time for the patient to receive a discount on his bill and the business office would have the patient's account ready at the time of his discharge. The earlier discharge hour meant the nursing staff would have completed all the activities of the patient's departure and be ready for a new patient during the hours when the day staff were on duty, thus relieving the work load of the evening staff.

The recommendation for earlier discharge was passed to the administrator by the proper channels but at first it did not appear feasible: there were too many people involved, *i.e.*, the doctors, the patients, the housekeeping department and the business office. However, when all the facts were made known to all the parties concerned the recommendation was adopted as policy.

Ward Manuals and Job Descriptions

Now a few words about the ward manual and job descriptions as devices for communicating and also as methods of acquainting new staff members with the scope of their activities and the procedures carried out in the hospital.

Experts in administration declare that the larger and more complex the organization, the more likely it is to attempt to manage its affairs on a predetermined basis and apply rules and regulations to precise situations. To judge each case on its merits as the need arises is time consuming and leads to confusion. On the other hand, a good administrative practice is to routinize and standardize. Some critics of this system apply the term bureaucracy with all its unpleasant connotations. But, whether we like it or not, some form of bureaucracy is necessary in the complex hospital situation today.

The ward manual should contain such routines as the regulations for x-ray and laboratory tests, narcotic control, consultations in certain operations, discharges and admissions. Examples of chart forms and requisitions for diet, supplies, drugs, et cetera, should be included.

If the manual is to provide up-to-date information—and it loses its value if it doesn't—it should be under constant revision as policy and procedures change. Some hos-

pitals combine procedures and ward routines in one manual. Others provide two—one for procedures and another for hospital policies and ward routine—on the premise that information is more readily available. Of prime importance in this respect is a good index.

But, ward manuals *per se* do not solve all the problems met in introducing new staff to the department nor do they define what procedures can safely be done by the various categories of workers. It is the inclusion of the job description which helps to limit the hazards involved in the use of the non-professional worker by outlining the duties she is permitted to carry out and indicating to whom she is responsible. The job description, apart from being a useful tool in setting up equitable salary schedules, fixes responsibility and accountability. It should give the title of the position, a summary of the duties to be performed and the responsibility involved. The relationship of the job to those above and below in the supervisory ladder should be shown.

Personnel Policies

Many hospitals, which have collected data on the problem of staff turnover, report an average length of employment of six months among the nursing personnel. Some units experience a rate of 95 per cent turnover in one year. There are various reasons why nurses move from one position to another and quite often the location of the hospital is a major factor in the failure to attract and retain staff. Some of the reasons nurses give for resigning are: general working conditions, unequal work load, too much shift work, poor living accommodation, wish to travel, home responsibilities, or a better position.

The matter of salary does not appear to loom too largely on the troubled scene and other factors more vital than pay require our attention. In most fields of endeavour other than nursing, both in and out of hospitals, business closes down at five o'clock, over the weekends and statutory holidays. Hospital patients, however, take no holidays but arrive at the hospital and go home any day of the week and at any hour of the day. This demands something extra from nurses for they often cover for other departments for the evening and night shifts and over the weekends. Many thousands of nurses

meet these demands or the unattractive shifts would go unstaffed.

Securing adequate staff, in terms of both quality and quantity, is one of the great difficulties facing the matron of a rural hospital. Often the staff is recruited from local residents who have some other reason for being in the community—usually their husbands are employed in the vicinity or the nurses wish to be near elderly parents. Unmarried nurses prefer the cities where social opportunities and professional advantage are more prevalent.

Because of the limited resources in rural areas, concessions have to be made and time schedules need to be flexible to accommodate part-time workers. If married nurses are employed, there may be a conflict between home and hospital responsibilities. These cannot be resolved through coercion or scolding; it is much more satisfactory to make adjustments through mutual agreement. However, the agreement should be reached before the nurse is employed so that she will have a clear understanding of what is expected of her.

This brings us to the written statement of conditions of employment. The personnel policies for the hospital should be in writing and clearly understood by the employee. If an employee handbook is not in use, a letter to the employee should state the position to be filled, salary to start and increments if any, hours of work, vacation schedule and sick leave allowance. If certain adjustments are being made for an individual employee, for instance the nurse who can only work three days a week, a statement to this effect should be contained in the letter. Good staff relationships are maintained if the employee's expectations about his work are fulfilled. ■

Congress on Mental Health

The Sixth International Congress on Mental Health will be held at the Sorbonne, Paris, from August 30 to September 5, 1961, under the auspices of the World Federation for Mental Health. The congress will provide an opportunity for an inter-professional, cross-cultural appraisal of mental health throughout the world and activities in progress in this field; for reporting on work carried out in connection with World Mental Health Year 1960; and for planning for the period ahead.

The main theme of the congress will be those of World Mental Health Year: the needs of children and youth; national surveys in the field of mental health and ill health; teaching of the principles of mental health; mental health and the sociological aspects of industrial change; mental health and migration; and mental health and ageing.

The congress will be open to professional workers in psychiatry, psychology, education, nursing, social work and allied fields; and to non-professional people interested in the promotion of good mental health and human relations throughout the world.

Requests for further information should be addressed as follows: from all parts of the world except North and South America, to: Ligue Française d'Hygiène Mentale, 11 rue Tronchet, Paris 8, France; and from North and South America, to: World Federation for Mental Health, 162 East 78th Street, New York, 21, N.Y., U.S.A.

Not in the dictionary: Conceit—a queer disease which makes everybody sick except the one who has it.

Really thrifty buyers compare *lifetime* costs, not just prices

When you select a temperature control system, keep in mind that price is only the *beginning* of the story, for your lifetime cost will include operating expenses and maintenance expenses as well as first cost. It takes *all three* to give you a *true* cost picture.

Leading hospitals everywhere rely on Johnson Pneumatic Temperature Control Systems to meet the most exacting demands for both performance and economy. A specially designed Johnson System is the finest obtainable. And, of course, pneumatic controls are simpler, cost less to operate, require less supervision and upkeep, and will outlast any other type of controls you can use.

When you build or air condition, it's easy to make sure you get full value for your control dollar. Simply ask your architect, consulting engineer, or local Johnson representative for the facts about power consumption, expected length of equipment life, upkeep requirements, and other lifetime cost factors. You'll discover, as have so many other thrifty buyers, that Johnson offers you by far the lowest lifetime costs.

Johnson Controls Ltd., Toronto 16, Ontario. Direct Branch Offices in Principal Cities across Canada.

LOWEST LIFETIME COSTS

JOHNSON CONTROL

PNEUMATIC SYSTEMS

GROWING WITH CANADA SINCE 1912

What Opportunities

(continued from page 44)

to accept the responsibility? She needs to be developed, needs guidance and assurance if she is to perform to the standard expected. The problem needs immediate attention. Although we are beginning to see some changes in nursing education, we are, and will be, faced with the tremendous responsibility of providing each young man and woman entering nursing with the opportunity of being educated to the level of his or her full capacity.

How can we help the nurse become a leader in the situation? If we fail to develop her abilities and potentialities we are failing as employers and as leaders—which employers should be.

The first opportunity that should be provided for every graduate nurse is a *good* orientation program during which his or her place on the hospital team is made very clear. The nurses should understand that all about them are people to whom they are leaders. Their co-workers, particularly those with less preparation in nursing, are placing their confidence in them regarding patient care. Their patients are looking to them for guidance during their illness, as do visitors whose loved ones the nurse is caring for. The head nurse, who has assigned them their work and in making the assignment has given them the authority to manage that assignment, expects them to show leadership, as does the director of nursing who employed them and the public in general who respect nurses and nursing.

During the orientation period an endeavour should be made to establish where the nurses' abilities and potentialities lie and their assignments made accordingly. If the nurse does not use her ability and is not having her potentialities challenged she will become bored and with boredom comes job dissatisfaction. A dissatisfied employee is worse than none.

Orientation should be considered as the initial phase of the in-service education program and in this program you can let your imagination run rampant for ideas to encourage participation by individual nurses. The first which comes to mind is the leadership and help a nurse already in the situation can give a new staff member.

The nurse who expresses interest and the desire to study beyond the basic course should be encouraged

to do so, for out of interest comes ideas and effective activity. The latter is contagious, it snowballs into more quantity and better quality.

The nurse should be encouraged to identify herself with her professional association because she who isolates herself from outside professional activities is not aware of what the profession as a whole is endeavouring to accomplish. She is not keeping pace and she loses an opportunity for growth.

There is one thing being done by hospitals which, on behalf of the young graduate, I must raise my voice against. All too often, out of desperation to have a job filled by a body, a nurse who has just completed her basic education is placed in a position of responsibility beyond her experience and qualifications. The young graduate may not think so, she is pleased to be chosen; but how can a person who has been a student one day be a head nurse or supervisor the next? Giving the young person credit, she will try but she is being exploited! In situations where this is done, everyone is too busy to help her. No plan for development is laid down or, if it is, it is busy collecting dust away back on a shelf somewhere.

So far I have been saying the nurse this, the nurse that, she needs this, she needs that, as though the nurse was the only one who "needs". Let's take the mask off! Hospitals need more value for their money, they need a year's value in a week not a week's value in a year. Invest in *leadership*, it will pay enormous dividends. ■

Hospital Cooks

(concluded from page 60)

looked, that the institutes were the first of their kind in the province. The dietitians of the interior group of the British Columbia Dietetic Association did voluntarily plan and arrange one- and two-day workshops in 1956 and 1957. The institute was, however, the first opportunity that had been accorded to the majority of those attending, to get together and share experiences and discuss problems. Evaluation questionnaires indicated that the week was well spent and many expressed a desire for future institutes as well as extending them to include those who worked in the kitchens with them. ■

Even a mosquito doesn't get a slap on the back until he starts working.

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch of fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

STAFF APPLICATIONS INVITED

Georgetown & District Memorial Hospital will open in June, with 66 adult, 8 paediatric beds and 14 bassinettes. All facilities are built and equipped for future expansion. Located 36 miles from Toronto in lovely country town of 10,000. Housing shortage is non-existant in this friendly community. Applications are invited for:

Dietitian
Laboratory Technologist
X-Ray Technician
Accountant
Executive Housekeeper

Employment to commence about May 15. Full details to:

Administrator,
Georgetown & District Memorial Hospital,
Georgetown, Ontario.

Hospital Purchasing Agent

With 15 years' experience. Present position in 400 bed general hospital. Have thorough knowledge of all branches of hospital purchasing, including effective stock control.

Could be free to consider new position July 1, 1961.

Apply Box 427G, Canadian Hospital, 25 Imperial St., Toronto 7, Ont.

Director of Nursing

Applications are invited for the position of Director of Nursing for new 150 bed chronic and convalescent hospital to open September 1, 1961. Duties to commence on or after June 1, 1961. Apply stating experience and salary expected to:

Administrator,
Fort William Chronic and Convalescent Hospital,
Fort William, Ontario.

Hospital Administrator

Experienced, at present doing organizational work for a provincial Hospital Insurance Plan, looks forward to returning to hospital administration after the completion of present duties in June or July.

Apply to: Box 405S, Canadian Hospital, 25 Imperial St., Toronto 7.

Ontario Association of Institutional Laundry Managers

Western District

Announces Their

Annual Institutional Laundry Institute

to be held at

The Ontario Agricultural College

Guelph, Ontario

July 3rd-7th inclusive, 1961.

Subjects to be covered are: Washroom Technology—Plant Layout—Textiles—Job Training, etc.

For full information write to:

Mr. S. Hierons, Laundry Superintendent,
KITCHENER-WATERLOO HOSPITAL,
Kitchener, Ontario.

Medical Records Librarian Wanted

to assume the responsibility of the records department in a 160 bed general hospital. For further particulars please reply to Administrator,
Kirkland and District Hospital,
Kirkland Lake, Ontario

RESIDENT DOCTOR REQUIRED

A Resident doctor for New World Island, north-east coast of Newfoundland, to serve a population of 4,000 people.
To work in close association with staff of Notre Dame Bay Memorial Hospital on immediately adjacent island.
Remuneration: $10,000.00 per annum guaranteed and paid through Notre Dame Bay Memorial Hospital office, plus full maintenance, rent-free house, surgery and transportation.
Reply giving marital status, background and references to J. M. Olds, M.D., F.A.C.S. Twillingate, Newfoundland.

Medical Social Worker With University Preparation Required to head new department From July 1, 1961 BRANDON GENERAL HOSPITAL Salary commensurate with training and experience

APPLY TO: PERSONNEL OFFICER
BOX 280,
BRANDON, MANITOBA.

Director of Nursing

Applications are invited for the position of Director of Nursing in a 66 bed accredited hospital. An opportunity for one capable of maintaining an excellent standard ot nursing care with adequate and well-trained staff.

Well-equipped hospital, beautifully situated in the Niagara peninsula—just 10 minutes from downtown Buffalo.

Apply: Superintendent,
Douglas Memorial Hospital,
Fort Erie, Ontario.

Classified Advertising

Director of Nursing

Modern hospital with 42 adult beds and 11 bassinets has vacancy for Director of Nursing.

The hospital is located in a company operated town and serves a population of approximately 6,000. Community organized recreation. Residence accommodation and all conventional benefits available.

Salary range $387.-$507. per month, commensurate with experience and qualifications.

Apply giving particulars of training and experience to

Administrator,

ANSON GENERAL HOSPITAL

Iroquois Falls, Ont.

Dietitians

Applications are invited from qualified Dietitians, with membership in the Canadian Dietetic Association, for appointment to the post of Chief Dietitian at the Tuberculosis Sanatorium, St. John's, Newfoundland.

Salary is on the scale $3,900-$4,140, from which $710 per annum is deducted for Board and lodgings. Uniform and laundry services are provided. Transportation will be provided to Newfoundland for the successful applicant. Interested parties are invited to write, giving full details as to experience etc., to:

Secretary,

St. John's Sanatorium
St. John's, Newfoundland

An oil-rich sultan, who bought a Cadillac, paid for it with a $10,000 bill and said: "Give me my change in Volkswagens."

Dietitians

An opportunity for a different type of dietetic experience. Beginning salary $3,960 per annum. Must be eligible for C.D.A. membership. All letters of enquiry answered. Apply to:

Personnel Director,
Vancouver General Hospital
Vancouver 9, B.C.

Silence is Golden

A rather crusty old man invested in one of the new hearing aids that are almost invisible. A few days later he returned to the store to express his delight.

"I'll bet your family likes it too," said the salesman.

"Oh, they don't know I've got it," said the old fellow. "And in the past two days I've changed my will twice!"

OPERATING ROOM SUPERVISOR

required by

QUEEN MARY VETERANS HOSPITAL
Department of Veterans Affairs
MONTREAL, P.Q.

SALARY—$4050—$4710

Candidates must possess the following qualifications:

—Graduation from an approved school of nursing,
—Registration as a nurse in a province of Canada,
—Certificate of a completed course of recognized standing in operating room technique,
—Several years' experience in operating rooms,
—Evidence of administrative and teaching ability.

For further details and application forms write to

CIVIL SERVICE COMMISSION, OTTAWA.

Please ask for Information Circular 61-743.

HAMILTON GENERAL HOSPITALS

Invites applications from

Clinical Instructor
Student Course in Obstetrics

Clinical Instructor
Post-Graduate Course in Obstetrics

at the

Mount Hamilton Obstetrical Unit
of the above hospital

Applicants for the Post-Graduate Course should have at least one year post-graduate study at a recognized university. Good personnel policies and fringe benefits. Salary according to experience.

Applications to be forwarded to:

Superintendent of Nursing,
Mount Hamilton Hospital
Hamilton, Ontario.

SUPPLIERS TELL US—

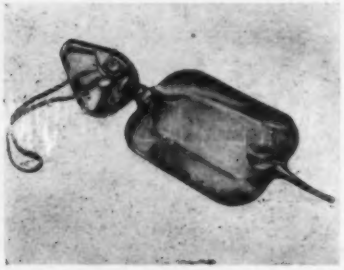
Interesting items from the news releases of hospital suppliers

By C.A.E.

Ohio Semi-Disposable Oxygen Therapy Masks

A new semi-disposable oxygen therapy mask has been introduced by Ohio Chemical and Surgical Equipment Co. (a Division of Air Reduction Company, Inc.) Madison 10, Wisconsin.

It is moulded of soft semi-rigid polyethylene. The contoured shape allows a comfortable snug fit on almost all patients. The masks are available in two styles, with a re-breathing bag or tubing connection directly on the mask.



For additional details, including prices, please request Catalogue Sheet No. 2471 from Ohio Chemical Canada Ltd., 180 Duke Street, Toronto 2, Ont.

Terrazzo and Marble Floors Need Special Care

Terrazzo and marble, for all their apparent hardness, need care just as do other types of flooring.

Because marble is of limestone formation (terrazzo is marble chips in cement) it is dissolved by acids and absorbs alkaline cleaning solutions which crystallize and expand as they dry, breaking down the walls of the pores and creating rough dull spots. For this reason strong cleaners should never be used on such floors.

Varnish or lacquer cannot be used as sealers as they will discolour the marble. Marble and terrazzo need sealing, however, to prevent stains and, in the case of terrazzo, prevent dusting or powdering of the cement through wear.

A product called Terra-New, made by Johnson's Wax, is made especially for such floors. It is a mixture of waxes, resins and a slip-retardant ingredient in a solvent base. It acts as a sealer on new terrazzo floors and prevents dusting. It is water-resistant and protects the floor from water-borne stains.

The product is available in janitor supply outlets. Further details may be obtained by writing to S. C. Johnson & Son, Ltd., Brantford, Ont.

Rusch of Canada Ltd. to Market Catheters

The Willy Rusch K.G., Rommelshausen, West Germany, manufacturers of the Rusch catheters and tubes, recently announced the opening of a branch office and warehouse in Canada. The office, Rusch of Canada Limited, will be located at 64 Gerrard St. E., Toronto 2.

The operation of this new Rusch subsidiary will be directed by the officers of the American Rusch Corporation in New York, Miss Buechle and Mr. Samet, and will be managed by B. C. Hollingshead, active for nearly 30 years in the Canadian surgical supply trade, who is also a director of the corporation.

President of the new company will be Werner Rusch; vice president, Heinz Rusch, and it was stated that this addition to the Rusch organization will permit them to offer their Canadian customers a more efficient service.

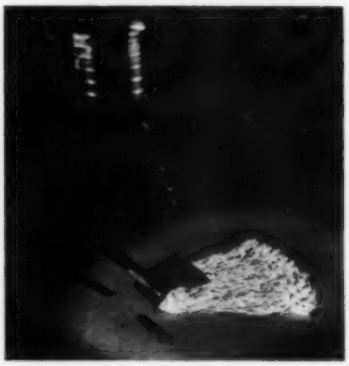
Marks on Floors Easily Removed While Wet Mopping

The simple addition of a small piece of synthetic floor scrubbing pad to a mop and handle can greatly extend the cleaning range of ordinary wet mopping. According to Geerpres Wringer, Inc., manufacturers of floor mopping equipment, occasional heel scuffs and similar black marks can be readily removed while wet mopping without the use of a floor machine.

Synthetic scrubbing and buffing pads, marketed for several years, have proven extremely effective in tile floor maintenance. By cutting a piece approximately 6" x 9½" and laying it over the top of a wet mop saddle, the pad can be installed in any non-clamp type mop handle. All Geerpres handles will accommodate the pads.

Resilient and non-absorbent, the pad flares away from the body of the mop and does not interfere with normal mopping or wringing. When black rubber marks or other tough soil are encountered, the pad is brought into action by folding it under the mop heel as shown. Light pressure on the mop handle loosens the soil immediately.

Some of the firms manufacturing the synthetic pads have sizes ready-cut to the approximate dimensions previously mentioned. Others have the material available in rolls so that it is not necessary to destroy



the round scrubbing pads used with floor machines. Geerpres Wringer and their jobbers will be happy to supply names of manufacturers of this material upon request.

Further particulars available from Geerpres Wringer, Inc., Muskegon, Mich.

General Electric Implements Advanced X-Ray Techniques

Current x-ray equipment demands from the medical profession met a massive response from the General Electric Company. The response found expression in an across-the-board array of new diagnostic products unveiled at the 1960 Radiological Society of North America convention.

Designed by the firm's Milwaukee, Wisconsin, X-Ray Department to implement the most advanced radiological techniques, the new General Electric equipment includes:

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Suppliers Tell Us —

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A "power everything" x-ray table—the "Monarch";

An all-medium system (mirror optics, motion picture, closed-circuit TV) for the presentation of intensified x-ray images — the "Fluoricon";

An x-ray generating unit built to deliver the right amount of power, in the right time increment, for high-speed radiography—the KX 8-11;

A high-powered, self-contained, explosion-proof mobile x-ray unit for operating room use — the EP-300;

An explosion-proof tube unit designed specifically for operating where the presence of anaesthetic gas constitutes a volatile hazard; and

Two fluoroscopic x-ray tube units adaptable to grid control for cine-fluorography—the HRT VII and VIII.

In addition to unveiling the results of its response to current radiological equipment needs, General Electric probed the future of the profession by displaying an equipment system—"Teletrol" (as illustrated) that embodies a departure from the traditional concept of fluoroscopic examination.

This concept, reflecting a trend in radiology, permits remote control of many fluoroscopic procedures. In this system the radiologist sees his patient through a lead glass window and a bank of TV monitors, and talks with him through an intercom. One of the monitors presents an intensified fluoroscopic image. The radiologist remotely controls the positioning of the patient, x-ray table, fluoroscopic tube, the x-ray image intensifying and recording devices. He also has control of all electrical factors and is sealed off completely from the radiation exposure area. Radiation to the patient is also reduced through use of the image intensifying system.

G. E. Williams, medical marketing manager of General Electric's X-Ray Department, says "Teletrol" was displayed primarily for evaluation by radiologists attending the convention—that it is still in the evolution stage. He stated, however, that this system and the remote-control concept it represents would be made available to meet the expressed needs of the profession.

Décor Executive Posture Chair by Royal Metal

The Royal Metal Manufacturing Co. Ltd. of Galt, Ontario, has unveiled Model No. 1290, the latest addition to its colourful Décor line of modular office furniture.

Reflecting today's trend to clean, modern lines in office furnishings, this Canadian designed executive posture chair features the new high look, and provides full-length support for the back and neck.

While the chair was primarily designed to complement the Décor line of desks, its attractive appearance would enhance any executive office, and give it a modern look.

Décor seating features delightful shades in either leatherette or fabric coverings, gunstock or natural walnut arm-rests, and the usual rugged Royal construction. Each chair comes with a 10 year structural guarantee.

Richard Gaunt to Represent Legion Line in Canada

Mr. V. K. Scavullo, vice president, Legion Utensils Co., Inc., of Long Island City, New York, has announced the appointment of Richard Gaunt of Gaunt Steel Products, Ltd., in Toronto, as a representative for the Legion products, covering the provinces of Ontario and Quebec.

The Legion utensils line includes Hospital Tray Service, Dri-Hot Plates, and the Multi-Egg-Fryer. Mr. Gaunt will also represent Legion Equipment Co., Inc., and their line of Kettles and the Legion Stainless Sink Corporation range of Stainless Sinks.

In commenting on this appointment Mr. Scavullo stated, "Our business in Canada has continued to increase pacing the economic growth in the country. In order to provide our dealers with more service on the Legion line, we are delighted to add Mr. Gaunt to our staff of representatives."

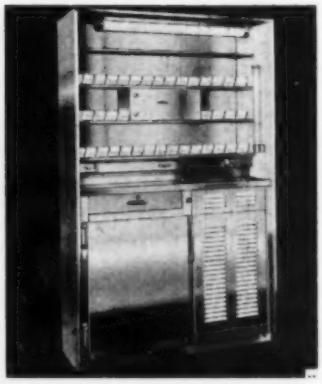
Legion Utensils Co., Inc., maintains their manufacturing headquarters offices and showrooms at: 21-07 40 Avenue, Long Island City 1, New York.

The Market Forge Medi-Prep Medicine Station

A new development in systematic, time-saving patient care has been announced by Market Forge Company.

The Everett, Mass. firm, whose Medi-Prep Medicine Station is the first scientifically designed hospital work station offered as a standard product, has introduced a new model designed for the storage of each patient's medicines in individual removable containers.

Featuring removable plastic trays on each shelf, the nursing staff can store and dispense prescribed medications from the patient's individually labelled bottles. Card holders are furnished for each tray for positive patient identification.



Each tray also is equipped with

(Continued on page 100)

Wabasso double-duty sheets are the only ones in Canada woven specifically for hospital use...

WABASSO weaves these heavy-quality sheets to stand up to the exceptionally hard wear and numerous launderings demanded in hospitals. But they're tightly woven of *fine* yarns to give a smooth to the touch surface so essential to patients. *These made-in-Canada* WABASSO *sheets are also available in hospital green—through your local wholesaler or hospital supply house. The Wabasso Cotton Company Ltd.*

Halifax, Montreal, Toronto, Winnipeg, Vancouver

Suppliers Tell Us —

(continued from page 98)

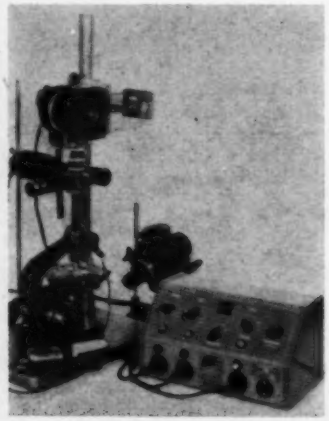
three dividers which simplify the storing and identifying of all medicines. Trays are 2¾" wide, 10¾" long, 1⅞" dep. A clear height of eight inches between shelves allows room for the largest bottles.

Available with or without shatterproof glass doors, the new Medi-Prep Medicine Station Model No. MP-248, aids the hospital in charging more accurately the costs of medicines and adds immeasurably to patient safety.

For further information, write to the Market Forge Company, Everett 49, Massachusetts.

The Versatile Wild Universal Microscope Lamp

In most cases, research processes in medicine as well as industry require a tremendous amount of control work and checking, particularly in the developing stage. This is when the time lapse equipment comes in handy and has even become indispensable. The new Wild solution offers fully automatic manipulation of exposure, transport of film, turning off the illumination, turning on light source, new exposure, et cetera. The periods between exposures are freely adjustable to such an extent that it should meet all requirements. The switching off and on of the light source, so far unique in the market, is of vital importance with living cells and bacteria.

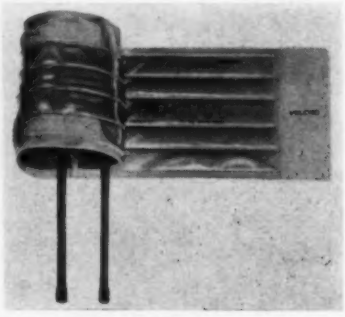


The versatility of the Wild universal microscope lamp has been increased even further. In addition to the xenon or mercury vapour high pressure burners, a new ribbon filament lamp can be installed. This illumination resembles the low voltage lamp but the lamp ribbon, in place of a common filament, guarantees a much higher and a more homogeneous luminosity of the field of view. The luminous flux is very regular and not affected by current undulations.

Write for detailed information to Wild of Canada Ltd., 157 MacLaren St., Ottawa 4, Ont.

New Features in Baum Blood Pressure Apparatus

The new Air-Lok Cuff, with Velcro, combines the outstanding advantages of the amazing new fabric fastener, Velcro, with the exclusive features of a sealed-in inflation bag. The non-absorbent material is easier to kep clean, and the use of a Velcro closure means easier application to the patient's arm. Because the cuff fits better, less pumping of the inflating bulb is required.



The Air-Lok Cuff with Velcro is the result of intensive research in cuff design, materials and fabrication methods. Before its introduction, this new cuff had been subjected to thorough factory inspections and extensive field tests over a period of six months to assure perfect performance in day-to-day use.

The manufacturer guarantees to replace free of charge any Air-Lok Cuff found defective in any way. Available through surgical supply dealers. Further specifications and information from W. A. Baum Co., Inc., Copiague, N.Y.

Linde Releases Medical Film on Hypoxia

A new medical film, presenting a general survey of the causes and effects of hypoxia, has been released by Union Carbide Canada Limited, Linde Gases Division. This 30 minute, 16 mm., colour, sound motion picture is presented by Edwin Rayner Levine, M.D., and reviews the basic physiology of respiration and demonstrates clinical recognition of the major types of hypoxia.

After reviewing apparent symptoms of hypoxia induced by exercise in a normal adult, Dr. Levine discusses true hypoxia in asthma, broncho-pneumonia, pulmonary edema, and in typical postoperative patients. After pointing out the use of oxygen therapy for these conditions, the film features an unusual photographic sequence of tissue hypoxia produced by coronary artery ligation in a dog's heart, and its improvement by oxygen inhalation.

This film's presentation of how to recognize and treat hypoxia makes it of great importance to all doctors who encounter clinical hypoxia whether they are specialists or GPs.

Designed primarly for the practising physician, this film should also be helpful as a medical school teaching aid, because of the discussion on basic respiratory physiology. It should also be of great interest to inhalation therapists, supervisory nurses, and other hospital staff personnel concerned with care of the patient.

For further information write Union Carbide Canada Limited, Linde Gases Division, Department 500, 123 Eglinton Avenue East, Toronto 12, Ont.

Hubbert Introduces Wall Mounted Steam Jacketed Kettle

B. H. Hubbert & Son, Baltimore, Md., has introduced a self-contained electric-fired steam jacketed cooking kettle, to be wall mounted at any practical height.

Model TWER is easily installed and maintained. There are no exposed pipes under the kettle, a fea-

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ture which eliminates accumulation of foreign matter; saves cleaning time and labour.

Food may be cooked at any temperature between 70° and 250° F. Thus products may be cooked, simmered or merely kept hot, with heat regulated by thermostatic control.

Its standard tangent outlet is equipped with a 1½" NA compression type faucet, but can also be furnished with a 2" or 3" faucet, at a slight additional charge. The larger faucets allow for quick discharge of such foods as stews, chowders, puddings, diced or creamed potatoes, et cetera.

This kettle is made in 20, 30, 40 and 60 gallon capacities.

Hubbert presents complete details on Model TWER in folder No. a-30. Address: 1311 S. Ponca Street, Baltimore 24, Md.

Canadian representatives are Alloy & Steel Fabricators of Canada Ltd., 169 Bartley Dr., Toronto 16, Ont.

J. H. White Retires After Forty Years with Bard-Parker

After more than four decades with the firm, J. Harry White has retired as executive vice president and general manager of Bard-Parker, Inc., Danbury, Conn.

Morgan Parker, the firm's president, states that while his active service as administrative head of Bard-Parker, a position he has held since 1932, has ended, Mr. White will continue to act as a consultant. He will be succeeded by Stanley Olsen, who has been acting as Mr. White's assistant and has been with Bard-Parker's parent company, Becton, Dickinson and Company, Rutherford, N.J., for the past 20 years.

Mr. White joined Bard-Parker as general sales manager in 1920 in New York City. When the firm moved to Danbury in 1933, Mr. and Mrs. White became residents of Bethel.

He has been a civic and charitable leader in both communities, serving as chairman of the Danbury chapter of the American Red Cross and vice chairman of the Advisory Board and life member of the Salvation Army. He has headed the Bethel Board of Education and the Danbury Chamber of Commerce, been a member of the state board of education and the Connecticut State Board for the Employment of the Physically Handicapped, to name only a few of his activities.

Victor Cameron is New Hardie Representative

G. A. Hardie & Co., Limited, Toronto, announce the appointment of Victor Cameron, of Brantford, to

cover the general area of Guelph, Kitchener-Waterloo, Brantford, and the Niagara Peninsula. He will continue his residence in Brantford.

Appointments at the J. F. Hartz Company

The J. F. Hartz Company Limited announces the appointment of John A. Kennedy as vice-president and general manager. Mr. Kennedy has served the company for 30 years, the last ten as sales manager.

A new member appointed to the board of directors is Bruce Howard, manager of the Hamilton branch office. Mr. Howard had been with the company's head office in sales before transferring to Hamilton as manager.

John A. Kennedy

Bruce Howard

The manager of the Montreal Branch, T. C. Stokes, has announced his retirement after serving the company since 1912, and as manager of the Montreal office since 1924. The Board appointed Mr. A. Spiers as manager of the Montreal office to replace Mr. Stokes, and Mr. A. Lebrun as the office manager.

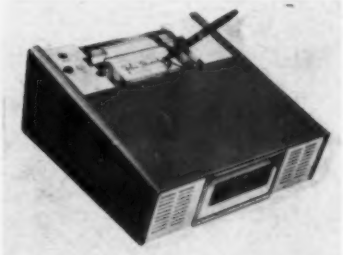
New Telautograph Transmitter Features Direct Writing

Automatic Electric Sales (Canada) Limited, announces the new TELautograph Direct Writer Model D, a new compact version of the well known TELautograph transmitter that features direct writing with a ball point pen on paper and increases transmission distances.

The direct writing feature eliminates writing in one place while watching another, and allows the use of multi-carbonized forms. There is no stylus and no messy ink.

The Direct Writer Model D, which is AC operated, uses a DC amplifier and allows the user to write to as many as 50 receivers simultaneously within a radius of up to 50 miles, with increased transmission accuracy. Maximum power consumption is 50 watts.

Because the Model D is fully transistorized, it requires no station box, but is entirely self-contained in a case 12 inches wide by 12 inches deep by 5½ inches high at the back tapering to 4 inches at the front.



The whole transmitter weighs only 22 pounds. Selective switching for transmitting to specific stations is available in a separate housing.

For full information write Automatic Electric Sales (Canada) Ltd., 185 Bartley Dr., Toronto 16, Ont.

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PROFESSIONAL DIRECTORY